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A STUDY TO DETERMINE THE MOST COST-EFFECTIVE METHOD OF DELIVERING OBSTETRICAL CARE TO ALL ELIGIBLE BENEFICIARIES WITHIN THE KENNER ARMY COMMUNITY HOSPITAL'S CATCHMENT AREA.

A Graduate Research Project Submitted
to the Faculty of Baylor University in Partial
Fulfillment of the Requirements for the Degree
of
Master of Health Administration

by

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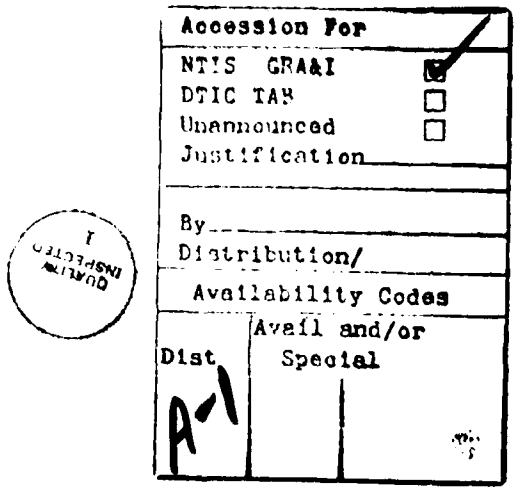

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INTRODUCTION

The Obstetrician's dilemma: Today's obstetricians are beleaguered hybrids of Don Quixote and King Canute. The windmills they tilt are the buffeting forces generated by consumer groups, the government, third-party payers, and the legal system. Among the tides they are asked to hold back, are the rising rate of cesarean sections and the growing demand for a perfect product every time. Their earnest desire to accommodate all these demands is thwarted by the realization they cannot succeed, given the current limitations of the discipline and the almost impossible objectives (Spellacy, 627).

Today's rapidly evolving health care field requires that executives be on target with their competitive strategies. Each day health care executives are presented with multiple routes and approaches toward creating a competitive advantage. And their decision can mean the difference between boom and bust. When faced with strategies that land on opposite ends of the spectrum, the military health care administrator's versatility is needed.

The civilian health care system and the practice of medicine have entered a period of rapid change. The forces propelling this change are formidable. With the advent of government intervention, in the form of flat rate reimbursement, and the emergence of alternate health care delivery systems, this decade is experiencing the industrialization of medicine. The rise of complex interacting corporations who own the facilities, underwrite the cost of care, manage the plans, and employ or retain physicians, will have important consequences in the near future. Restraint will govern the use of marginally beneficial tests. Wohl advocates that amidst the turmoil that surrounds the health care industry, the professional level of care delivered in this country is still the highest quality available on earth (Wohl, 178).

Major changes have occurred in medicine during the past few years. The number of medical students who graduate each year has recently doubled. The federal government

pays a significant portion of health care costs and the body of scientific information is expanding logarithmically (Raines, 840). Obstetrics, like many other medical specialties, is experiencing the convergence of a number of diverse medical, social and economic trends. As a result, there is increasingly intense turmoil in how these services are clinically delivered and managed. There is a profound shift from predominantly inpatient institutionalized care to outpatient care.

The leaders of the United States Army Medical Department must be alert to these changes if they expect their clinics and inpatient facilities to survive and deliver the best possible care under a rapidly changing set of expectations. If our leaders fail to recognize these pressures and thereby fail to create timely strategic reactions, our military hospitals may subsequently experience a loss in productivity in the future. The issue in obstetrics is not merely one of determining how best to manage obstetrics clinics, but of how to recognize the changes and prevalent patterns and to begin devising responsive management strategies.

Conditions Which Prompted the Study

High costs, wide beneficiary dissatisfaction, and inadequate readiness for war have stirred widespread interest in changing the military's system of health care. Large sums are at stake because of the military health care system's scope. The Army, Navy, and Air Force run 129 hospitals (medical centers and regional and community hospitals), and several hundred outpatient clinics in the United States. About 9 million people are entitled to use these facilities, including not only the 2.2 million men and women serving on active duty their roughly 3 million dependents, along with about 4 million retired military personnel and their dependents and their survivors. Caring for dependents and

retirees (nonactive beneficiaries) in military facilities costs the Department of Defense more than $3 billion a year (Congressional Budget Office, 7).

When nonactive beneficiaries cannot obtain care directly from the armed forces because a particular medical service is unavailable, or because the military facilities are hard to reach, they may use the Civilian Health and Medical Program of the Uniformed Services.

Civilian Health and Medical Program of the Uniformed Services

Civilian Health and Medical Program of the Uniformed Services supplements care provided directly in military facilities (direct care) and has antecedents that go back more than 30 years. Before 1956, military beneficiaries who could not get direct care were on their own. The Congress remedied this in 1956 by approving a plan called "military Medicare," which paid for some hospitalization, minor surgery and for maternity care. In 1966, the Congress expanded military Medicare to cover outpatient care, psychiatric care, and prescription drugs-just the sort of comprehensive coverage offered by leading private health insurance plans of the day. To avoid confusion with Social Security's Medicare, military Medicare was renamed Civilian Health and Medical Program of the Uniformed Services in 1968 (Congressional Budget Office, 5).

With costs exceeding $2 billion a year (Congressional Budget Office, 13), the Civilian Health and Medical Program of the Uniformed Services funds 300,000 hospital admissions, 6 million outpatient visits, and several million ancillary procedures annually. In practice, Civilian Health and Medical Program of the Uniformed Services is chiefly an insurance program for hospital care, since approximately three-quarters of its payments go to civilian hospitals or to other inpatient professionals. Until this year, Civilian

Health and Medical Program of the Uniformed Services almost always paid hospitals' billed charges in full, an increasingly archaic practice for a major health care payer. Legislation enacted by Congress in 1985 linked Civilian Health and Medical Program of the Uniformed Services to Medicare-thus obliging hospitals that accept Medicare payments also to accept Civilian Health and Medical Program of the Uniformed Services payments. Under this system, Civilian Health and Medical Program of the Uniformed Services will pay hospitals a fixed fee per patient, the specific amount depending on the patient's diagnostic classification. The Department of Defense expects that using Diagnois Related Groups will reduce Government's expenditure in health care by $150 million in 1988 and by $300 million in 1989; the latter equals a sizable share of Civilian Health and Medical Program of the Uniformed Services's budget, but less than 3 percent of the cost of all military medical activities.

Civilian Health and Medical Program of the Uniformed Services pays a large part of the costs of care obtained from civilian hospitals and doctors. Dependents and retirees can use Civilian Health and Medical Program of the Uniformed Services whenever they want for outpatient care, but for hospital care those living in a catchment area-the area roughly 40 miles around a military hospital-must get specific permission from their local military medical commander. In recent years funding for Civilian Health and Medical Program of the Uniformed Services has tripled, from about $710 million in 1980 to more than $2 billion in 1987 (Figure 1).

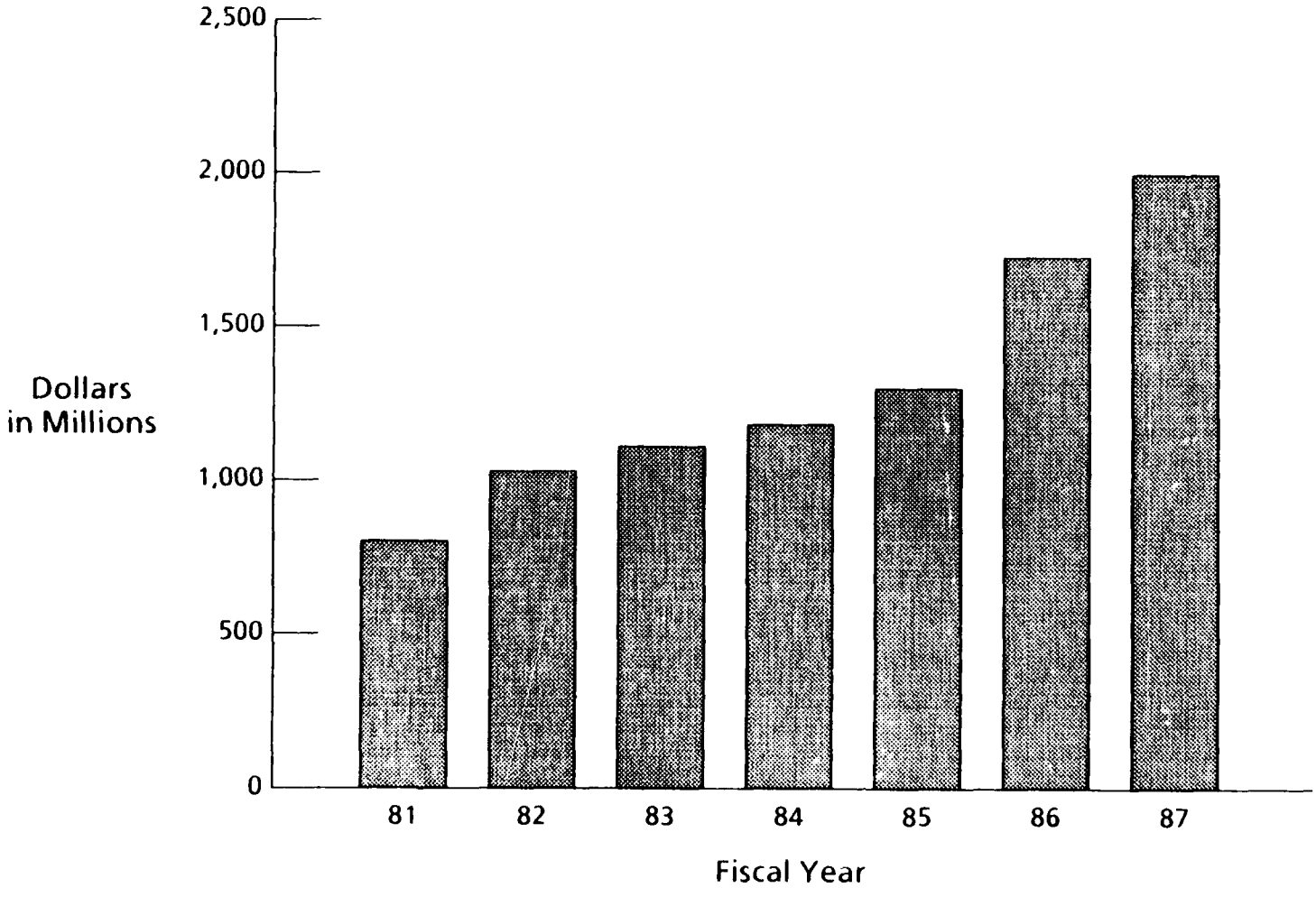
Soaring costs are a principal reason the Pentagon is adamant about reforming Civilian Health and Medical Program of the Uniformed Services. The program cost $2.3 billion in Fiscal Year 1987: up 57% from $1.3 billion in FY 1985. Between 1981 and 1987 program costs more than doubled. From 1983-1986 Civilian Health and Medical Program

of the Uniformed Services costs increased at a rate of 50% faster than total health care costs (Gagnon, 168) . The problem of access to prompt military medical care at a reasonable cost continues to leave medical commanders throughout the Department of Defense in a quandary.

Growth in CHAMPUS costs, 1981-1986 (in millions)

Source: CHAMPUS

Growth in CHAMPUS Costs (source: *OCHAMPUS*, 1988)



In fiscal years 1986 and 1987, Kenner Army Community Hospital continued to experience increases in the amount of funds expended to provide obstetric services to its beneficiaries (Office of The Surgeon General - OTSG, Medical Summary Report, R-3). A significant percentage of funds disbursed, excluding personnel costs, were for obstetric services (Civilian Health and Medical Program of the Uniformed Services, 3). All obstetric services for active duty soldiers are paid for by the Supplemental Care Program; Civilian Health and Medical Program of the Uniformed Services pays for the non-active duty patients. These beneficiaries have been receiving obstetric care in local civilian institutions since 1976 when the Kenner Army Community Hospital obstetrical unit was closed by Health Services Command due to a shortage of Obstetricians in the U.S. Army and the low number of deliveries performed at Kenner Army Community Hospital. The number of patients receiving obstetric care averaged 600 per Fiscal Year and will continue to average about the same unless the mission of Fort Lee is changed markedly. The Kenner Army Community Hospital Chief of Resource Management Division currently allocates $800 for physician services and $3,000 for hospital services for each active duty obstetric case. The Fiscal Year 1986 U.S. Army Civilian Health and Medical Program of the Uniformed Services and Supplemental Care Program cost for obstetrical was $1,675,158 and $315,084 for Supplemental Care Funds for a total of $1,990,242. In Fiscal Year 1987 the cost for the same services to the Civilian Health and Medical Program of the Uniformed Services was $1,746,606 and $391,375 for care rendered to Active Duty soldiers for a toal of $2,137,981, in addition to the deductibles the retirees had to pay (Civilian Health and Medical Program of the Uniformed Services, 3).

In an effort to maximize resources and reduce Kenner Army Community Hospital and Department of Defense patient care costs for obstetric services, the executive

management at Kenner Army Community Hospital requested that research be conducted to determine the best option of providing obstetrical care, with particular emphasis on cost efficiency, effectiveness and patient participation.

Statement of the Problem

The problem statement of this study is to determine the most cost-effective method of delivering obstetrical care to all beneficiaries within the Kenner Army Community Hospital catchment area.

Objectives

The objectives which must be achieved to accomplish this research project are:

1. To review applicable literature pertaining to the delivery of obstetric care.
2. To review Kenner Army Community Hospital regulations, policy statements and procedures.
3. To develop a preliminary model outlining current patient referral procedures.
4. To determine the beneficiary population in the Fort Lee catchment area.
5. To review the documentation used to establish the Joint Health Benefit Delivery Program within Department of Defense.
6. Using Civilian Health and Medical Program of the Uniformed Services data determine the cost of obstetric care in fiscal years 1986 and 1987.
7. To determine the cost of obstetric care for the active duty soldier expended through Supplemental Funds in fiscal years 1986 and 1987.
8. To conduct a cost-benefit analysis of providing obstetric care under the current system.

9. To conduct a cost-benefit analysis of providing in-patient obstetric care using military manpower at Kenner Army Community Hospital.

10. To conduct a cost-benefit analysis of providing in-patient obstetric care using contract physicians at Kenner Army Community Hospital.

12. To conduct a cost-benefit analysis of providing obstetric care using the Internal Partnership Agreement Program.

11. To conduct a cost-benefit analysis of providing obstetric care using the External Partnership Agreement Program.

13. To conduct a cost-benefit analysis of providing obstetric care by exploring joint ventures with the local civilian healthcare institutions.

14. To establish definitive constraints of each option.

15. To determine the additional personnel, facility, and equipment requirements needed if obstetric care is to be provided at Kenner Army Community Hospital.

Assumptions

For the purpose of this study, the following assumptions will apply:

1. The current obstetric services will not be curtailed during the study.

2. Patient data collected from fiscal years 1986 and 1987 are an adequate basis for the study.

3. No mission changes affecting the delivery of obstetric care will occur during this research period.

4. Civilian Health and Medical Program of the Uniformed Services will decentralize management of its funds to the medical treatment facility commander in fiscal year 1989 or 1990.

Criteria

For the purpose of this study, the following criteria will be used:

1. Standards for obstetric care published in the 1988 Accreditation Manual for Hospitals by the Joint Commission on Accreditation of Health care Organizations.

2. Standards for obstetric care published by the American College of Obstetrics and Gynecology.

3. ZIP codes will be used to identify the Civilian Health and Medical Program of the Uniformed Services eligible population and the Patient Administration Division's Medical 302 Reports will be utilized to identify the active duty population.

4. Cost-benefit analysis will be based on fiscal years 1986 and 1987 Civilian Health and Medical Program of the Uniformed Services cost, workload, and health care summary statistics for the non-active duty beneficiaries and Kenner Army Community Hospital's Command Performance and Review Analysis will be used to determine the cost of the Supplemental Care Program.

5. Services to be considered under the program cannot require the construction of a new facility.

Limitations

The scope of the study is limited to Kenner Army Community Hospital.

Research Methodology

A review of the literature was accomplished by reviewing workload documentation from existing programs as provided by the Health Services Command Patient Administration Division and Civilian Health and Medical Program of the Uniformed Services data from 1 October 1985 through 30 September 1987. The Civilian Health and Medical Program of the Uniformed Services beneficiary population in the catchment area was determined to be 91,000 by examining Health Systems Agency data, Civilian Health and Medical Program of the Uniformed Services Non-Availability Statements and the Civilian Health and Medical Program of the Uniformed Services Healthcare Summaries.

The projected cost of ancillary personnel to support Obstetricians/Gynecologists, equipment, facility costs were calculated and based upon estimates provided by the Fort Lee Directorate of Engineering and Housing, Civilian Personnel Office, Kenner Army Community Hospital's Logistics Division, Personnel Division, Resource Management Division, and Patient Administration Division's health care statistical branch. For the services to be recommended under the Partnership Programs or the Joint-Venture option, the total cost of personnel, equipment and the retrofitting of existing facility could not exceed the cost of providing the service through Civilian Health and Medical Program of the Uniformed Services in a civilian facility.

Demographic and medical care data as described in the objectives were evaluated to determine the major commonalities in the population of concern and assisted in determining the types of obstetrical care that should be included in the Partnership Programs-if it should be included.

The financial feasibility of the Partnership Programs was evaluated by comparing the costs of the six options at Kenner Army Community Hospital/civilian hospitals against the full Civilian Health and Medical Program of the Uniformed Services allowable costs for the same or similar service provided in a civilian health care facility. Civilian Health and Medical Program of the Uniformed Services information was indicated in the Non-Availability Statements for Health Services Command and the Health Services Command Uniformed Chart of Accounts analysis of selected indicators. The cost of the Partnership Programs and the Joint Venture option had to be less than the current Civilian Health and Medical Program of the Uniformed Services costs.

Interviews were conducted either in-person or via telephone and the six options were discussed. Colonel Mark Arner who serves as the consultant to The Surgeon General for the Obstetrician/Gynecology specialty, stated that the supply of Obstetricians in the near future was bleak. The reduction in Incentive Pay due to Dr. William E. Mayer's (Assistant Secretary of Defense for Health Affairs) acknowledgement of Obstetrics and Gynecology as a non-wartime specialty has resulted in a greater than expected exodus of this specialty from the military. Colonel Arner remarked that a minimum of 1000 deliveries would be necessary to warrant an obstetrical service in-house. Historical data show that the Fort Lee community has never had a demand of 1000 deliveries in a Fiscal Year. Additionally, there are other larger medical activities and centers that have to be resourced who currently meet the criteria and lack adequate staffing.

The Chief of Surgery at Kenner Army Community Hospital remarked that with an adequate number of obstetricians, inpatient obstetrics can be facilitated. However, this is contingent upon the Department of Surgery having its full complement of three

general surgeons. There are an adequate number of anesthesists and an anesthesiologist to facilitate the current workload of deliveries at Kenner Army Community Hospital. The obstetric services will require additional nurses in the Neo-Natal Intensive Care Unit.

CHAPTER II

Joint Health Benefits Delivery Program Literature Review

The Joint Health Benefit Delivery Program was a Department of Defense directed program established on 10 January 1983 in accordance with Department of Defense 6010.12. The purpose of the program was to integrate specific Civilian Health and Medical Program of the Uniformed Services and military medical treatment facilities resources. It allowed Defense Eligibility Enrollment System enrolled Civilian Health and Medical Program of the Uniformed Services beneficiaries to receive inpatient related outpatient services, inpatient medical care, and ambulatory care surgery services from contracted civilian health care providers within military *treatment facilities.*

Implemented by the military treatment facility commander, the Joint Health Benefit Delivery Program objectives included reducing Civilian Health and Medical Program of the Uniformed Services costs, providing medical services that otherwise were unavailable in the military treatment facility, attempted to improve the military treatment facility's productivity and increase Civilian Health and Medical Program of the Uniformed Services beneficiary use of the military treatment facilities, while assisting in the overall Department of Defense cost containment effort. However, effective 22 October 1987, the Internal and External Partnership programs replaced the Joint Health Benefit Delivery Program.

CHAPTER III

Professional Services: Obstetrical Care

Civilian Health and Medical Program of the Uniformed Services

Literature Review

Obstetrical services are reimbursed as an all-inclusive global maternity professional fee which includes all professional services normally provided for routine antepartum care, vaginal delivery (with or without episiotomy, or forceps or breech delivery) and postpartum care.

Civilian Health and Medical Program of the Uniformed Services maternity care begins when the beneficiary becomes pregnant and continues through delivery,to include the first six weeks' check-up after the baby is born (Civilian Health and Medical Program of the Uniformed Services FS-8, 2). Maternity care is defined as care needed due to pregnancy including complications from pregnancy. Treatment of nonpregnancy related conditions such as a broken leg, are not covered under Civilian Health and Medical Program of the Uniformed Services maternity care benefits. Civilian Health and Medical Program of the Uniformed Services maternity care costs are cost shared by the beneficiary. The amount is determined by the frequency of care, the status of the beneficiary, and whether the baby is delivered in an inpatient or outpatient setting. Beneficiaries under this program include spouses and unmarried children of active duty soldiers, retirees, spouses of retirees and their unmarried children and the spouses and unmarried children of deceased active duiy and retired service members.

Special provisions of the Civilian Health and Medical Program of the United

Services Program should be understood prior to utilization of maternity benefits to avoid nonreimbursement of services or other cost sharing dilemmas. Circumstances may require more than one pregnancy-related admission during the maternity birth episode. In this case, all admissions are considered to be a single admission for cost sharing purposes, regardless of the number of days between admissions, even when the beneficiary is admitted to more than one hospital. Only Civilian Health and Medical Program of the Uniformed Services approved birthing centers can be utilized when the program cost-shares the delivery and maternity care fees on an inpatient basis. Although military health care facilities are not permitted to refer patients to a particular organization, some hospitals, to include Kenner Army Community Hospital, provide listings of supplemental health insurance plans to assist beneficiaries who must fulfill cost-sharing requirements. Beneficiaries planning to deliver at home must receive a Non-Availability Statement prior to going to the hospital if home delivery complications arise.

Prescription drugs related to the maternity episode are payable on an inpatient or outpatient basis depending on the status of the patient at the time of the delivery or other termination of pregnancy (i.e. miscarriage). However, prescription drugs provided on an outpatient basis which are not directly related to obstetrical care would be cost-shared on an outpatient basis even though administered during the maternity episode. Under normal circumstances, no separate cost-share would be collected for the newborn, as the newborn is not considered a separate admission, but is included in the mother's admission. Traditionally, Civilian Health and Medical Program of the Uniformed Services has considered routine newborn care (nursery charges, etc.) as part of the maternity episode, and the cost of the newborn was considered a part of the mother's admission expense. This no longer applies under the Civilian Health and Medical Program of the Uniformed Services DRG-based payment system that went into effect I

October 1987. There are separate DRGs for the mother and the newborn, therefore all newborn services must be billed separately from the mother's claim. In the case of multiple birth, separate claims must be submitted for each newborn. Nursery charges and newborn services for the infant child of an unmarried dependent are no longer covered. A child of an unmarried dependent is not a Civilian Health and Medical Program of the Uniformed Services beneficiary.

The cost-sharing provisions for newborn services have been changed. On the fourth day of the newborn's life Civilian Health and Medical Program of the Uniformed Services will apply a cost share to his/her account (CHAMPUS/CHAMPVA News, 2).

Example: Date of Birth - 1 October 1987

Date of Discharge - 5 October 1987

Active Duty: No cost share would be applied to baby's claim for services from 1-3 October, however, for 4-5 October a $25.00 total cost-share would be applied. If the baby's claim shows a date of admission different than the date of birth, the cost-share is applied to all inpatient days. The cost-share for active duty dependents is $25.00 or $7.85 a day, whichever is greater (CHAMPUS/CHAMPVA News, 3).

Cost-share for Retiree and CHAMPVA Dependents

No cost-share is applied to the newborn's claim if the inpatient stay for the baby is three days or less. If the baby stays for more than three days the cost-share is 25

percent of the baby's total bill or $175.00 a day for each day over three, whichever method results in the lesser amount. The cost-share will never exceed the Diagnosis Related Groups allowable amount. These cost-sharing rules apply only to Diagnosis Related Groups reimbursed institutions.

Non-Availability Statement Requirements For Maternity Care

In case of maternity, the date of admission will be defined as the date when the patient entered into the prenatal care program with a civilian provider and the maternity Non-Availability Statement shall remain valid until 42 days following termination of the pregnancy. Also, in the event that a newborn remains in the hospital continuously after the discharge of the mother, the mother's Non-Availability Statements shall be deemed valid for the infant in the same hospital for up to 15 days after the mother's discharge (CHAMPUS/CHAMPVA NEWS, 5). Beyond the 15 day limit, a claim for non-emergency inpatient care must be accompanied by a valid Non-Availability Statements in the infant's name. Beginning 1 October 1987, separate claims are required for the mother and the newborn. This does not change the requirement for a Non-Availability Statement for maternity care and the mother's Non-Availability Statement will continue to cover the newborn for routine care. A Non-Availability Statement is not required when the mother is an active duty soldier. However, at birth the newborn of an active duty becomes a Civilian Health and Medical Program of the Uniformed Services beneficiary. A Non-Availability Statement will not be required for routine care of a newborn of an active duty member, but if a newborn becomes a patient in its own right, normal Non-Availability Statement requirements are applicable. Just as for cost-sharing determinations, the care is to be considered routine if less than four days.

CHAPTER IV

Military-Civilian Health Services Partnership Programs

Literature Review

A memorandum issued by the Office of the Assistant Secretary of Defense for Health Affairs outlines the objectives of the Partnership Programs. The Military-Civilian Health Services Partnership Program is a new program to improve health care services to beneficiaries and reduce costs both for beneficiaries and Department of Defense. The objective is to help reverse recent trends of services becoming less available in military treatment facilities, forcing more care onto Civilian Health and Medical Program of the Uniformed Services. For example, hospital admissions in military treatment facilities decreased about 60,000, while those in Civilian Health and Medical Program of the Uniformed Services increased by about the same amount, from Fiscal Years 1985 to 1987. A comprehensive narrative of the Partnership Programs can be found in Appendix A. The Partnership Program is intended to help restore levels of medical services in military facilities by allowing civilian physicians and other providers to reduce military hospital staff shortages. This will also improve beneficiary access to services and be less costly than providing the care in the civilian community under the regular Civilian Health and Medical Program of the Uniformed Services program.

The Partnership Program allows civilian physicians and other providers, possibly accompanied by support personnel, equipment and other resources, to come into the military treatment facility in order to supplement the services not available in the military treatment facility. The civilian provider charges are then billed to Civilian

Health and Medical Program of the Uniformed Services. In this way, the two components of the Military Health Services System, the military component (military treatment facility) and the civilian component (Civilian Health and Medical Program of the Uniformed Services), are brought together in a beneficial partnership. The military treatment facility provides the facility and Civilian Health and Medical Program of the Uniformed Services handles the civilian provider's fee. This increases the effectiveness of both components of the system by making better use of military treatment facility capacity and avoiding the greater costs of health care in the civilian sector under the normal Civilian Health and Medical Program of the Uniformed Services program.

Under the Partnership Program, military treatment facility services are expected to increase, thereby improving access to care. In addition, beneficiaries will pay less under the Partnership Program than they must pay under normal Civilian Health and Medical Program of the Uniformed Services. Rather than the higher Civilian Health and Medical Program of the Uniformed Services cost-sharing amounts, including deductibles and copayments, beneficiaries will pay as little as $25, rather than the normal Civilian Health and Medical Program of the Uniformed Services cost share of 25 per cent.

The Partnership Program is designed to limit civilian hospitalizations-the most costly portion of the Civilian Health and Medical Program of the Uniformed Services budget (Table 1). Ideally, this will help contain health care costs. For example, an inpatient admission in the civilian sector under the normal Civilian Health and Medical Program of the Uniformed Services program generally produces two separate bills: one from the hospital for all hospital charges and one from the physician for the fees associated with the care. Under the Partnership Program, if the hospital services can be provided in the military treatment facility, the civilian hospital charges can be totally avoided. In addition, the physician's fee will likely be discounted under the Partnership

agreement. Local providers agreed that the average overhead cost associated with each patient ranged from 35-40 per cent. The result is lowered costs because of the reduced expense of the military hospital compared to the civilian hospital and the probability of a discounted phsyician fee. The Partnership Program is also available to supplement outpatient services, where it can also increase services and efficiency. Cost savings through the Partnership Program should allow more services to be provided within the limited Department of Defense health care budget.

The Partnership Program is intended to supplement other methods now in place that seek to reduce military treatment facilities staff shortages. For example, military treatment facilities have been able to arrange for personal services contracts with civilian providers to treat patients in the military treatment facilities, but these contracts may only apply to a limited group of providers and require substantial administrative process to establish. In addition, the Joint Health Benefit Delivery Program has allowed Civilian Health and Medical Program of the Uniformed Services-funded physicians to provide care in military treatment facilities, but it was not widely used because of numerous limitations regarding covered providers, administrative procedures and substantial beneficiary cost sharing requirements. The Partnership Program provides a valuable new tool to help reduce military treatment facility staff shortages.

The Partnership Program is part of an effort to restore health care services in military treatment facilities. Other aspects of this effort include a new budgeting method, under which managers of the military medical departments will now have financial responsibility for Civilian Health and Medical Program of the Uniformed Services. This recognizes the impact on Civilian Health and Medical Program of the Uniformed Services of uncertain levels of services in military facilities and rewards medical program managers who avoid higher Civilian Health and Medical Program of the

Uniformed Services costs by restoring military treatment facility services. Department of Defense hopes this restoration of services will permit the reduction of the number of Non-Availability Statements issued in fiscal year 1988 to the number issued in fiscal year 1986.

A new Department of Defense Instruction has been issued by the Assistant Secretary of Defense for Health Affairs to establish the Partnership Program. Under this Instruction, the primary responsibilty for using the Partnership Program rests with the military treatment facility Commander. The Commander is encouraged to establish partnership agreements when it will: 1) meet a need for health care services; 2) be more economical for Department of Defense than the regular Civilian Health and Medical Program of the Uniformed Services program; 3) be consistent with the mission of the military treatment facility; and 4) maintain the high military treatment facility standards of quality health care.

TABLE I

Civilian Health and Medical Program of the Uniformed Services Health Care Summary By Primary Diagnosis
Based on care received from 1/10/85 thru 30/09/87
Kenner Army Community Hospital, Fort Lee, Virginia

Category of Care - Obstetrics	FY 1986	FY 1987
I INPATIENT HOSPITAL SERVICES		
User Beneficiaries	414	411
Depnt of AD sponsor	369	369
Retiree	1	0
Dependent of Ret or Dec Sponsor	44	42
Total Hospital Admissions	468	457
Hospital Days	1,672	1,610
Average Length of Stay (Days)	3.57	3.52
Average Daily Patient Load	4.58	4.41
Total Government Cost	1,033,974	1,055,571
Total Patient Cost	81,407	67,376
Total Govt and Patient Cost	1,115,381	1,122,947
Avg Govt Cost Per Admission	2,209.35	2,309.78
Avg Govt Cost Per Day	618.41	655.63
II INPATIENT PROFESSIONAL SERVICES		
User Beneficiaries	753	744
Depnt of AD Sponsor	685	683
Retiree	1	1
Depnt of Ret or Dec Sponsor	67	63
Number of Visits	591	590
Number of Non-Visit Services	1,986	2,471
Total Government Cost	502,422	560.967
Total Patient Cost	28,168	38,837
Total Govt and Patient Cost	531,168	599,804
III TOTAL INPATIENT SERVICES		
User Beneficiaries	793	802
Depnt of AD Sponsor	721	732
Retiree	1	1
Depnt of Ret or Dec Sponsor	71	72
Total Govt Cost	1,536,395	1,616;538
Total Patient Cost	110,152	106,213
Total Govt and Patient Cost	1,646,547	1,722,751
Avg Govt Cost Per Admission	3,282.90	3,537.28
Avg Govt Cost Per Day	918.90	1,004.06

IV	OUTPATIENT PROFESSIONAL SERVICES		
	User Beneficiaries	36	35
	Depnt of AD Sponsor	30	28
	Retiree	0	0
	Depnt of Ret or Dec Sponsor	6	7
	Number of Visits	43	13
	Number of Non-Visit Services	67	39
	Total Govt Cost	5,798	2,885
	Total Patient Cost	1,678	1,371
	Total Govt and Patient Cost	7,476	4,256
	Avg Govt Cost Per Visit	134.84	221.92
V	OUTPATIENT CARE COST SHARED AS INPATIENT		
	User Beneficiaries	85	75
	Depnt of AD Sponsor	84	75
	Retiree	0	0
	Depnt of Ret or Dec Sponsor	1	0
	Total Govt Cost	21,142	18,969
	Total Patient Cost	(7)	629
	Total Govt and Patient Cost	21,135	19,598
VI	TOTAL INPATIENT AND OUTPATIENT CARE		
	User Beneficiaries	806	818
	Depnt of AD Sponsor	733	745
	Retiree	1	1
	Depnt of Ret or Dec Sponsor	72	76
	Total Govt Cost	1,563,335	1,638,393
	Total Patient Cost	111,823	108,213
	Total Govt and Patient Cost	1,675,158	1,746,606

CHAPTER V

Status of Obstetricians/Gynecologists in the Military

Colonel Mark Arner serves as the consultant to The Surgeon General of the Army for the specialty of Obstetrics/Gynecology. On 5 February 1988, Colonel Arner in a phone conversation with this author portended a shortage of these speacialists. This is primarily due to the Assistant Secretary of Defense for Health Affairs contention that obstetricians are a "non-wartime specialty." In a memorandum dated April 26, 1988 the Assistant Secretary for Health Affairs, Dr. William E. Mayer, denied the Armed Services medical departments' requests for Obstetric/Gynecology to be included as a "most critical" specialty for Incentive Special Pay (U.S. Medicine June 1988, 1). The reduction in Incentive Special Pay and the surgical specialties recognition as specialty of choice have infuriated Obstetrician/Gynecologists. A illustration of declining and increasing medical specialties are provided in Figures 2 and 3. Table 2 lists the specialty by Area of Concentration.

Increasing Medical Specialties-Ratio 1988/1984 Staffing

(Source: *HSC, DCCS,* June 1988)

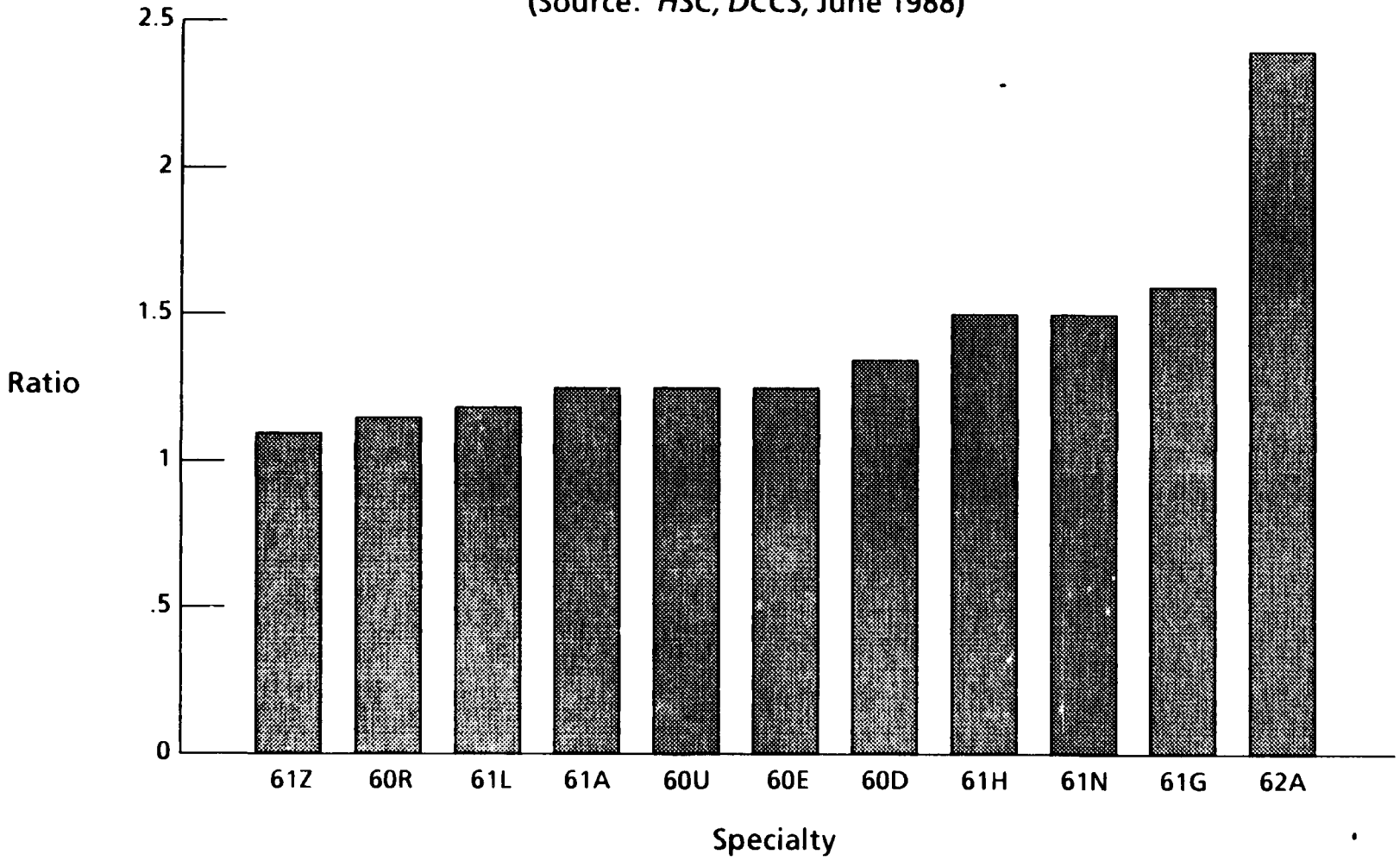


TABLE 2

60A Operational Medicine Officer
60B Nuclear Medical Officer
60C Preventive Medicine Officer
60D Occupational Medicine Officer
60E General Medical Officer

60F Pulmonary Disease Officer
60G Gastroenterologist

60H Cardiologist
60J Obstetrician and Gynecologist
60K Urologist
60L Dermatologist
60M Allergist/Clinical Immunologist

60N Anesthesiologist
60P Pediatrician
60Q Pediatric Cardiologist

60R Child Neurologist

60S Opthamologist
60T Otorninolaryngologist

60U Child Psychiatrist
60V Neurologist
60W Psychiatrist

60Z Hematologist

61A Nephrologist
61B Medical Oncologist
61C Endocrinologist
61D Rheumatologist
61E Clinical Pharmacologist
61F Internist
61G Infectious Disease Officer
61H Family Physician
61J General Surgeon
61K Thoracic Surgeon
61L Plastic Surgeon
61M Orthopaedic Surgeon
61N Flight Surgeon
61P Physiatrist
61Q Therapeutic Radiologist
61R Diagnostic Radiologist
61S Radiologist
61T Anatomical Pathologist
61U Pathologist
61V Clinical Pathologist
61W Peripheral Vascular Surgeon
61Z Neurosurgeon
62A Emergency Physician

Dr. Mayer was quoted as saying that "As you know, obstetricians are not the provider of choice for the majority of wartime surgical tasks. Rather, we plan to employ them as substitutes for any unavailable but nevertheless preferred general surgeons in wartime." Dr. Arner stated the memorandum was a "slap in the face" and was compounded by the arrival of another memorandum on the same day from Dr. Mayer which berated the military medical services for failing to provide adequate Obstetrics/Gynecology care to women on active duty-including "unacceptably long" waiting times to see a Obstetrician/Gynecologist.

The impending doom for this specialty has materialized with the loss of the graduate medical education program in obstetrics/gynecology at Letterman Army Medical Center in San Francisco. Dr. Arner also stated that 33 per cent of the community hospitals do not have a board certified gynecologist on staff. There are no military physicians in this specialty at Fort Lee, Fort Dix and Fort Devens. Dr. Arner predicts that a similar loss is going to result at Fort Hood, Fort Leavenworth and Fort McClellan within the next three months.

Dr. Arner cited that a fallacy exists at the higher levels of Department of Defense that the civilian malpractice crisis is so severe for Obstetric/Gynecologys that it will drive them into the military. He notes that the "floodgates are wide open, and there is no water behind them." Dr. Arner stated that he has currently two applicants-and they are physicians from the other service branches.

The Accreditation Council for Graduate Medical Education states that a variety of specialties must be present and frowns on a general surgery training program without the availability of pediatrics and Obstetric/Gynecology. The Council advocated that one cannot have a part of the system sit there waiting for war. Yet the Department of Defense seems convirced that they can do that despite all inputs. The Council warns that programs at other installations are in jeopardy (U.S. Medicine, June 1988, 1).

CHAPTER VI

DISCUSSION

The Increasing Need For Cost-Containment

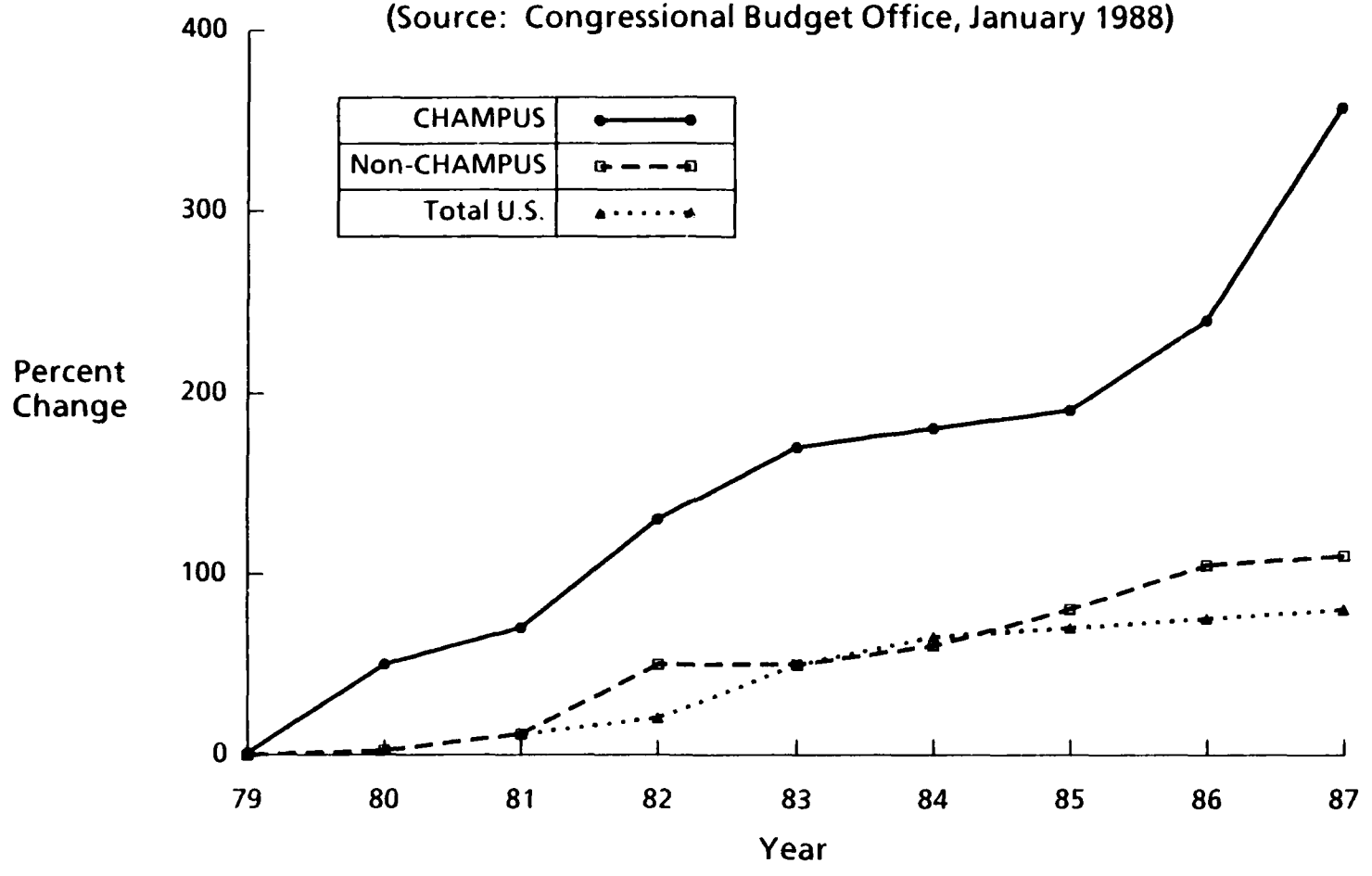
Rapidly escalating costs have earned Civilian Health and Medical Program of the Uniformed Services a troubled reputation. While the cost of all non-Civilian Health and Medical Program of the Uniformed Services military activities has risen by roughly 145 per cent since 1979-at a somewhat faster pace than total U.S. spending for health-the cost of Civilian Health and Medical Program of the Uniformed Services has risen by 365 per cent. In dollar terms, outlays for all military medical activities rose from about $4.1 billion in 1979 to $11.1 billion in 1987, while Civilian Health and Medical Program of the Uniformed Services expenditures went from $485 million in 1979 to $2.3 billion in 1987. These trends are shown in Figure 4.

The rapid growth in Civilian Health and Medical Program of the Uniformed Services costs has led to major shortfalls in budgeted funds: in 1982, $105 million was shifted from other Department of Defense programs, while in 1986 Civilian Health and Medical Program of the Uniformed Services received $360 million in supplemental funds. Civilian Health and Medical Program of the Uniformed Services spent its entire $1.5 billion 1987 budget by 25 June 1987. It then received an additional $425 million in supplemental funds, which were spent by the first week of September 1987. More money was needed because of an increase in cost of medical care as well as an

increase in the use of Civilian Health and Medical Program of the Uniformed Services by military dependents and retirees who were allegedly being turned away from crowded military hospitals (Army Times, 5 October 1987).

Trends in Medical Outlays

(Source: Congressional Budget Office, January 1988)



Escalating Civilian Health and Medical Program of the Uniformed Services costs are a product of growing numbers of military retirees and dependents, and high medical inflation. In 1986 medical prices rose four times faster than the Consumer Price Index. This was reported in a study conducted by the Congressional Budget Office in January 1988. The study found that a central reason Civilian Health and Medical Program of the Uniformed Services costs have risen is that in 1986 the services cut back the availability of care in the United States to nonactive beneficiaries. Despite the increasing numbers of dependents and retirees, military hospitals admitted 7 percent fewer of them in 1986 than in the year before and military clinics received 4 percent fewer outpatient visits from them (Table 3). The inevitable shift of beneficiaries to civilian care, paid for in part by Civilian Health and Medical Program of the Uniformed Services, raised costs not just for Civilian Health and Medical Program of the Uniformed Services but for the system as a whole, because it is generally cheaper to treat patients in existing military facilities.

TABLE 3

Summary of Workloads in Treating Non-Active Duty Beneficiaries in Fiscal Year's 1985 and 1986 in the United States.

Type of Care	Number (In thousands) 1985	1986	Percent Change 1985 to 1986
Direct			
Hospital Admissions			
Army Facilities	244.8	242.3	-1.0
Navy Facilities	142.6	110.8	-22.3
Air Force Facilties	206.6	198.0	-4.2
Total	594.0	551.1	-7.2
Outpatient Visits a/			
Army Facilities	10,295	10,245 b/	-0.5
Navy Facilitites	6,758	5,665	-16.2
Air Force Facilities	9,415	9,455	+0.4
Total	26,468	25,365	-4.1
CHAMPUS			
Hospital Admissions	288.4	315.0 c/	9.2
Outpatient Visits	4,926	5,876 c/	19.3

SOURCE: Congressional Budget Office tabulation based on department of Defense, Selected Medical Care Statistics, and other data provided by the Defense Medical Systems Support Center.

a. Includes office visists and ancillary visits.

b. Does not include about 70,000 visits to a civilian-run outpatient clinic (PRIMUS).

c. Based on data that are about 88 percent complete for the full fiscal year.

Civilian Health and Medical Program of the Uniformed Services' difficulties are thus symptomatic of broader problems in the military health care system. In particular, military medical managers and health care providers lack incentive, and perhaps resources as well, to supply quality care efficiently to nonactive beneficiaries. Additionally, beneficiaries themselves have little incentive to use medical services economically. Providers and patients therefore both behave in ways to create a central problem: the heavy use of military medical care services.

The Civilian Health and Medical Program of the Uniformed Services program started Fiscal Year 1988 with a deficit of nearly $115 million. The problem, several Pentagon sources said, was increasing use of Civilian Health and Medical Program of the Uniformed Services by beneficiaries in military hospital catchment areas. The overrun in Fiscal Year was about 37 per cent. The total Civilian Health and Medical Program of the Uniformed Services shortfall for Fiscal Year 1987 was more than $525 million. "There has been a shifting of the workload from the direct-care system to Civilian Health and Medical Program of the Uniformed Services," John Dexter, Deputy Assistant Secretary of Defense for Medical Resources Administration observed (U.S. Medicine, May 1988, 32). Initially it was shifting of retired beneficiaries, but now dependents of a active duty also are not able to acquire care in the direct-care system. When they go out on Civilian Health and Medical Program of the Uniformed Services it costs the government more money, because they pay less in cost sharing than retirees. The overrun is occurring primarily in inpatient care costs.

A congressional staff member said it appeared that the problem is not so much a decrease in workload in military hospitals but rather declining lengths of stay in military facilities and rising ones in the civilian hospitals handling Civilian Health and Medical Program of the Uniformed Services beneficiaries. "This means that either the civilian

hospitals are soaking Civilian Health and Medical Program of the Uniformed Services or the military treatment facilities are keeping the less expensive cases." Dr. Mayer cited that Civilian Health and Medical Program of the Uniformed Services rate continues to increase at a phenomenal rate for two reasons: the amount of care being provided in military hospitals continues to decrease; and we are paying more than we should in the civilian sector. Dr. Mayer said that the direct care system in 1987 admitted 58.000 fewer beneficiaries-an 8 per cent decrease-than in Fiscal 1985. Civilian Health and Medical Program of the Uniformed Services admissions in contrast have risen 22 per cent over the same period. Outpatient visits declined by 2.1 million between fiscal 1985 and 1987-a 7 per cent decrease-while Civilian Health and Medical Program of the Uniformed Services outpatient visits increased by 43 per cent (U.S. Medicine, May 1988, 32).

A big chunk of the overrun can be attributed to the fact that dependents of active-duty personnel pay no cost-share under Civilian Health and Medical Program of the Uniformed Services yet are using the program in greater numbers. The Congressional Budget Office study revealed that government pays, on average, 44 per cent more for active-duty dependent admission ($4,965) than for a retiree admission ($3,446) and 52 per cent more than for the admission of a retiree's dependent ($3,271). The Diagnosis Related Group payment system, which took effect 1 October 1987, for Civilian Health and Medical Program of the Uniformed Services is expected to save $150 million in fiscal year 1988.

OPTION I

CURRENT POLICY AND CHARGES

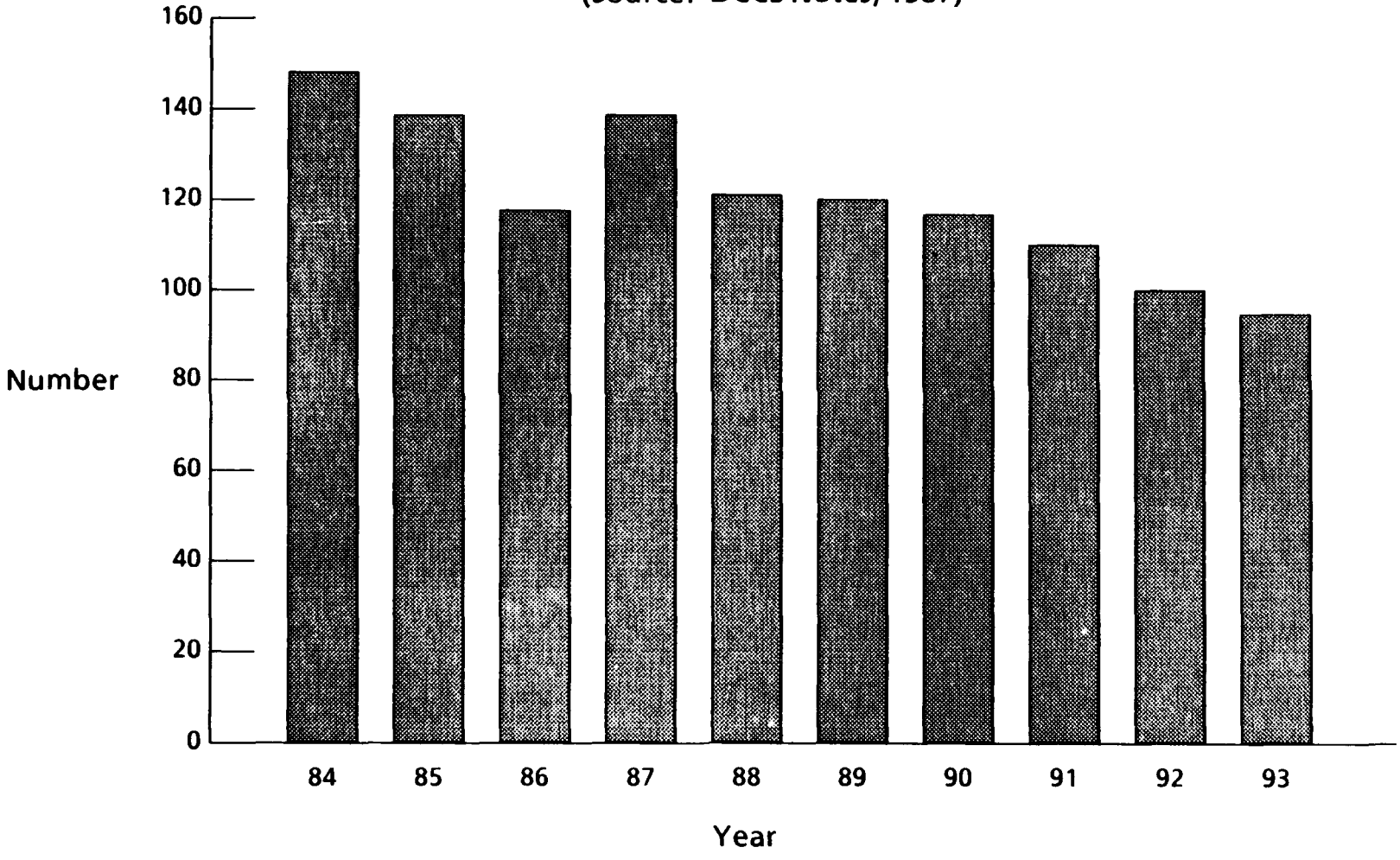
Current Policy

Both inpatient and outpatient obstetrical services were discontinued at Kenner Army Community Hospital in 1976 due to lack of obstetricians in the Army and a lower than necessary number of deliveries. This trend continues twelve years later as depicted in Figure 5.

Upon determination of pregnancy, patients are briefed on the availability of civilian hospitals (either John Randolph Hospital or Southside Community Regional Medical Center) both located approximately 4 miles from Kenner Army Community Hospital. Historical records from both Patient Administration Division and the civilian hospitals' Business Offices show that approximately 30 percent of the obstetric care has been provided by John Randolph Hospital and 30 percent by Southside Regional Medical Center. Forty percent of the deliveries have been delivered in hospitals in the Richmond community. A further investigation by the Office of the Civilian Health and Medical Program of the Uniformed Services Division of Statistics revealed showed that only 15 percent of those beneficiaries resided in the Richmond area. It is presumed that the remaining 25 percent of the women chose to deliver in more expensive hospitals like the HCA's Memorial Hospital in Richmond. A survey of thirty women who were issued statements of non-availability in February 1988 revealed that of the 13 (40 percent) who chose to deliver in the Richmond area, did so because of the perceived better quality of care than the local hospital. Albeit more expensive, these women did not care if they had to pay an extra $200-400 co-payment. The common fallacy persists that expensive care is quality care.

OB/GYN 60 J Actual and Projected Strength (1984-1993)

(Source: *DCCS Notes*, 1987)



Current Charges

Obstetrical services are reimbursed for an all-inclusive global Maternity professional fee which includes all professional services normally provided for routine antepartum care, vaginal delivery (with or without episiotomy, or forceps or breech delivery) and postpartum care. This is listed as procedure 59400 in the Physician's Current srocedural Terminology (Appendix B).

The following are the current costs associated with obstetrical care for both the hospitals and military beneficiaries both Active Duty and Civilian Health and Medical Program of the Uniformed Services eligible in the Tri-cities area of Petersburg, Hopewell and Prince George County, which includes Fort Lee.

Diagnosis Related Group based reimbursement: for physician charges	$1300.00
Civilian Health and Medical Program of the Uniformed Services prevailing average reimbursement rate (Appendix C) for hospital charges	
for mother	$1187.42
for baby	361.19
Total Reimbursement	$2848.61

Average Cost of Delivery at JRH, SRMC and area hospitals in Richmond

Length of stay = 2.4 days

Hospital average expenses - mother	$1550.00
- baby	410.00
Physician's average fees	1200.00
Average Total Expenses	$3160.00
Average loss incurred by the Hospital's per delivery	($311.39)
Average charged to KACH for an Active Duty Soldier	$3800.00
Average reimbursed by CHAMPUS for a delivery	$2848.61

Average overcharge to Supplemental Care funds per delivery ($ 951.39)

Civilian hospital's losses as a result of CHAMPUS reimbursement

FY 86 - 493 CHAMPUS deliveries x (311.39) loss = $153,515.27
FY 87 - 538 CHAMPUS deliveries x (311.39) loss = $167,527.82

Civilian hospital's gains as a result of overcharging KACH

FY 86 - 83 deliveries x ($951.39) overcharge = $ 78,965.37
FY 87 - 103 deliveries x ($951.39) overcharge = $ 97,993.17

The FY 1986 U.S. Army Civilian Health and Medical Program of the Uniformed Services and Supplemental Care Program cost was $1,740,000 for hospital services and $464,000 for physician services, for a total of $2,204,000 (Table 1).

If Kenner Army Community Hospital continues its current practice, it will lose an average of $951.39 per delivery. A memorandum of agreement needs to exist between the Commander and the local hospital representatives to match the charges of Civilian Health and Medical Program of the Uniformed Services patients and Active Duty soldiers. This would have netted a savings of $78,965.37 (fiscal year 1986) and $97,993.17 (fiscal year 1987) in Supplemental Care Funds.

Option 2

Comparison of providing inpatient obstetrical services at Kenner Army Community Hospital using military Obstetricians/Gynecologists

Inpatient obstetrical cost for Fiscal Year 1986 U.S. Army Civilian Health and Medical Program of the Uniformed Services and Supplemental Care Program was $1,675,158 and $315,084 for Supplemental Care Funds for a total of $1,990,242. In Fiscal Year 1987 the cost to the Civilian Health and Medical Program of the Uniformed Services was $1,746,606 and $391,375 for the obstetric care to Active Duty soldiers for a toal of $2,137,981, in addition to the deductibles the retirees had to pay (Civilian Health and Medical Program of the Uniformed Services, 3). Costs were based on historical Civilian Health and Medical Program of the Uniformed Services workload, actual personnel costs and estimated logistical requirements. Base support, engineer and logistical costs are not separated for estimation of overall base support expenses. Ward renovation (Appendix D), personnel (Appendix E), supplies and equipment (Appendix F) and acquisition can be accomplished for a first year cost of $1,546,362.80 (Table 4). Inpatient obstetrical and nursery services can result in an increased inpatient pediatric population. Pediatric inpatient services are not routinely provided at Kenner Army Community Hospital.

TABLE 4

OB Cost Analysis

	Year 1	Year 2	Year 3
Expenses:	$1,546,362.80	$1,114,543	$1,114,543
Personnel	1,011,527.00	1,011,527	1,011,527
Contract Physicians	482,000.00	482,000	482,000
Labor/Deliv/Pst Partum	314,042.00	314,042	314,042
Nursery	215,485.00	215,485	215,485
Nutrition Care	43,200.00	43,200	43,200
Equipment	253,819.81	0	0
Supplies (Med & Admin)	37,816.00	37,816	37,816
Ward Upgrade/Relocation	178,000.00	0	0
Custodial	22,000.00	22,000	22,000

OPTION 3

Analysis of providing inpatient Obstetrical Care using contract physicians at Kenner Army Community Hospital.

The Direct Health Care Provider Program, which was used to offset Medical Corps shortages, will not be funded at 100 per cent in Fiscal Year 1989 due to budgetary constraints. A conversation with Mr. Schultz from the Civilian Health and Medical Program of the Uniformed Services Division, Health Services Command, on 1 July 1988 revealed that only Emergency Medicine and the Radiology Direct Health Care Provider Program will be funded at the current 100 percent level in FY 1989. He also noted that the difference between the projected FY 1989 appropriations and the actual cost of the various Direct Health Care Provider Programs will have to be offset with local Medical Activity's Operation Maintenance Account. The Joint Health Benefits Delivery Program ended on 22 February 1988 with the hope that the Internal and External Partnership agreement programs will enhance both internal workloads and reduce Civilian Health and Medical Program of the Uniformed Services costs. The demise of the Direct Health Care Provider Program and the Joint Health Benefit DeliveryProgram are a result of spiraling costs, the absence of bids for remote areas, lack of continuity, uncertainty of funding on an annual basis, and an unacceptable number of Quality Assurance problems (Health Services Command Notes, 27 September 1988).

The notes from the annual Deputy Commander for Clinical Service Conference depict that the average contract cost for Obstetrics/Gynecology in FY 1988 is $140,000 (Appendix G). Based on an average of 600 deliveries annually, the contract cost for providing inpatient obstetrics care with the Direct Health Care Provider Program will

be $412,000. The Patient Administration Division's Health Benefits Advisor obtained from the Virginia Medical Society a list of all Obstetricians/Gynecologists in the state. A request to accept Civilian Health and Medical Program of the Uniformed Services assignment on a 100% basis form (Appendix H) was sent to 112 Obstetricians/Gynecologists. Of the 67 respondents, 11 did not agree to accept Civilian Health and Medical Program of the Uniformed Services assignment while 56 agreed to accept at the current level (Appendix I). The 8 Obstetricians/Gynecologists in the local Petersburg, Hopewell area all accept Civilian Health and Medical Program of the Uniformed Services assignments, but each rejected the idea of serving as a Direct Health Care Provider when canvassed.

OPTION 4

Internal Partnership Agreements

The internal partnership agreement is an agreement between a military treatment facility commander and a Civilian Health and Medical Program of the Uniformed Services authorized civilian health care provider which enables the use of civilian health care personnel at other resources to provide medical care to Civilian Health and Medical Program of the Uniformed Services beneficiaries on the premises of a military treatment facility. These internal agreements may be established when a military treatment facility is unable to provide sufficient health care services for Civilian Health and Medical Program of the Uniformed Services beneficiaries due to shortages of personnel and other required resources. In addition to allowing the military treatment facility to achieve maximum use of available facility space, the internal agreement is intended to result in savings to the Government by using civilian medical specialists to provide inpatient care in Government-owned facilities, thereby avoiding the civilian facility charges which would have otherwise been billed to Civilian Health and Medical Program of the Uniformed Services.

There are no current providers in the state of Virginia who are interested in entering into a Internal Partnership Agreement to provide for obstetrical care at Kenner Army Community Hospital. The two local hospitals currently average 1100 deliveries annually and the 8 local Obstetricians and groups are satisfied with their current obstetrical workloads.

OPTION 5

External Partnership Agreements

The external partnership agreement is an agreement between a military treatment facility commander and a Civilian Health and Medical Program of the Uniformed Services authorized institutional provider, enabling military health care personnel to provide otherwise covered medical care to Civilian Health and Medical Program of the Uniformed Services beneficiary in a civilian facility. Authorized cost associated with the use of the facility will be paid through Civilian Health and Medical Program of the Uniformed Services under normal cost-sharing and reimbursement procedures currently applicable under the basic Civilian Health and Medical Program of the Uniformed Services. Savings will be realized under this type agreement by using available military health care personnel to avoid the civilian provider charges which would otherwise be billed to Civilian Health and Medical Program of the Uniformed Services.

There are no obstetricians on staff at Kenner Army Community Hospital and therefore the External Partnership Program is not a viable option.

OPTION 6

Analysis of providing under a Joint-Venture with local hospitals

There were four meetings with the Chief Executive Officers, Chief Financial Officers of the local hospitals, two Obstetric/Gynecology practicing groups and 2 independent obstetricians. The discussions involved formulating a discount schedule, whereby, if the volume of both John Randolph Hospital and Southside Regional Medical Center were to increase, the savings would be divided equally between the Government and the hospitals.

It was a consensus that Obstetrics has traditionally been and continues to be a major loss leader in revenues for the hospitals. The Board of Trustees of both John Randolph Hospital and Southside Regional Medical Center disapprove of any joint ventures together. Bound by traditional rivalries, the two hospitals currently do not have any joint ventures, albeit in an economically depressed area. The Chief Executive Officers surmised that a tiered approach in soliciting discounts would be beneficial to both the hospitals and the Government. They premised their recommendations by stating that any increase in volume will allow them to narrow the difference between current reimbursement schedule and actual expenses per delivery. The following discount schedule was offered by both the Chief Executive Officers and can be affected if the local military treatment facility commander is allowed to direct his Civilian Health and Medical Program of the Uniformed Services eligible obstetric patients to either of the two local hospitals.

COST BENEFIT ANALYSIS

Current Hospital Average Expenses Per Delivery	$3,160.00
Current CHAMPUS Average Reimbursement	2,848.61
Current Average Loss Per Delivery	$ (311.39)

Projected Increase	Savings to Hospitals*	Discount to CHAMPUS/KACH*	Average Cost
5%	$160	$80.00	$2768.61
10%	279	139.50	2709.11
15%	395	197.50	2651.11
20%	576	288.00	2560.00

*-Per Delivery

Adjusting for 15 per cent of the Fort Lee beneficiary population who reside in the greater richmond Metropolitan area and referrng both Civilian Health and Medical Program of the Uniformed Services eligible patients and active duty soldiers to the local hospitals, the following savings can be realized by the Government. Both hospitals can accommodate a maximum increase of 15 percent volume in deliveries.

SAVINGS TO KACH

Current charges to KACH per delivery/with 5% discount

95* x $3,800 (No discount applied)	= $ 361,000.00
95* x $2,768.61 (Discount @ 5% = $ 80.00)	= $ 263,017.95
Savings to KACH	= $ 97,982.05

Current charges to KACH per delivery/with 10% discount

95* x $3,800 (No discount applied)	= $ 361,000.00
95* x $2,709.11 (Discount @ 10% = $139.50)	= $ 257,365.45
Savings to KACH	= $ 103,634.55

* Average of 95 deliveries annually from Supplemental Care.

SAVINGS TO CHAMPUS

Current charges to CHAMPUS/with 5% discount

500* x $2,848.61 (No discount applied)	= $ 1,424,305.00
500* x $2,768.61 (Discount @ 5% = $ 80.00)	= $ 1,384,305.00
Savings to CHAMPUS	= $ 40,000.00

Current charges to CHAMPUS/with 10% discount

500* x $2,848.61 (No discount applied)	= $ 1,424,305.00
500* x $2,709.61 (Discount @ 10% = $139.50)	= $ 1,354,805.00
Savings to CHAMPUS	= $ 69,500.00

* Average number of deliveries charged to CHAMPUS annually.

CHAPTER VII

Conclusions

The most cost-effective way to deliver obstetric care to all beneficiaries within the Kenner Army Community Hospital's catchment area is to provide those services on an in-patient basis at the facility. Economies of scale will be realized after the third year. However, innumerable statements by Dr. Mayer about the lack of need of Obstetricians in military medicine and the need to civilianize these services in U.S. Medicine (February 1988) and other presentations have resulted in the departure of many of these specialists in fiscal year 1988. U.S. Medicine (February 1988) cites a senior medical officer who states that Dr. Mayer has denigrated the practice of obstetrical specialty or has stood by while others of equal ignorance have done so. Most egregious of these attacks was by Senator Edward Kennedy who informed a hearing on the needs of military health care that if he were wounded in combat he would not want a gynecologist operating on him.

Under Dr. Mayer's policies to enhance the civilianization of military obstetrics, an edict went forth that Civilian Health and Medical Program of the Uniformed Services should be utilized for obstetrics and gynecology whenever possible, as they were not war-essential care areas. This, in spite of many European Army hospitals, where 10 percent of physicians are obstetricians and gynecologists accounting for 25 per cent of the admissions. Dr. Mayer has also mandated the cutting of pay for military obstetricians by decreasing their Incentive Special Pay (ISP). And he has decreed that they be paid far less than equally trained, often less productive surgeons, who do not have the expertise in the surgical care of women (U.S. Medicine, February 1988, 30).

The physician shortage that initially caused this shift from military to civilian medical care still exists today. The Office of The Surgeon General provided the

following data: The Army Medical Department is authorized 214 Obstetrician/Gynecologists. On 1 July the Army Medical Department has 181 (85 percent) of its authorizations. On 1 June 1988, the Office of The Surgeon General forwarded to the Secretary of Defense a projected strength of 157 (73 percent) Obstetrician/Gynecologists by December 1988. A recent loss of Graduate Medical Education Residency Programs at two of the Army's major medical centers will severely curtail the supply of new Obstetrician/Gynecologists in the next six months. The attrition rate is not keeping attendant with the Army Medical Department's ability to recruit or retain Obstetrician/Gynecologists. At present there are two Obstetrician/Gynecologists authorized at Kenner Army Community Hospital, with only one assigned since October 1987. The sole Obstetrician/Gynecologist practices only gynecology and treats primarily active duty soldiers. It is projected that a minimum of 5 Obstetrician/Gynecologists are required to meet the obstetric/gynecologic needs of the military beneficiaries. There are no additional authorizations for Obstetric/Gynecologists-nor the supply of these specialists.

CHAPTER VIII

Recommendations

The optimal solution is to alter the current practice of referring for obstetrical care. For the active duty soldier, the overcharges can be limited to the highest rate reimbursed by Civilian Health and Medical Program of the Uniformed Services and net an immediate savings of $94,182.05 in the Command's Supplemental Care funds annually.

A lack of Obstetricians in the Army Medical Department compounded with a higher than anticipated rate of attrition does not make the inpatinet delivery of obstetric care with military obstetricians a viable option. Albeit, economies of scale can be acheived in the cost of retrofitting existing ward C3 in two years, the personnel costs make this a less desirable solution.

The lack of interest from the 8 local obstetricians and others in the state of Virginai does not allow for Project External Partnership nor Direct Health Care Provider Program to materialize.

A joint venture with the two local hospitals will net the greatest savings in the future. The community overwhelmingly supports the current procedure and the local hospitals are willing to change the current charges billed for active duty to match the reimbursement by Civilian Health and Medical Program of the Uniformed Services. The greatest Civilian Health and Medical Program of the Uniformed Services benefits can be derived by reducing the 40% of deliveries which currently are delivered in Richmond, Virginia. Our inability to direct Civilian Health and Medical Program of the Uniformed Services patients to one of the two hospitals does

not allow for a Partnership Agreement where the charges can be discounted substantially. The Chief Executive Officer of John Randolph Hospital and Southside Regional Medical Center are willing to match discounts at 50% of the savings at 5% increments.

The greatest impact in savings will be realized when the local Commander will be authorized to manage Civilian Health and Medical Program of the Uniformed Services funds for his catchment area and direct the patients to a facility where we have the best discounts available. The decentralization of Civilian Health and Medical Program of the Uniformed Services funds are not projected to materialize until mid Fiscal Year 1989 according to Mr. Schultz at the Health Services Command's Civilian Health and Medical Program of the Uniformed Services Office.

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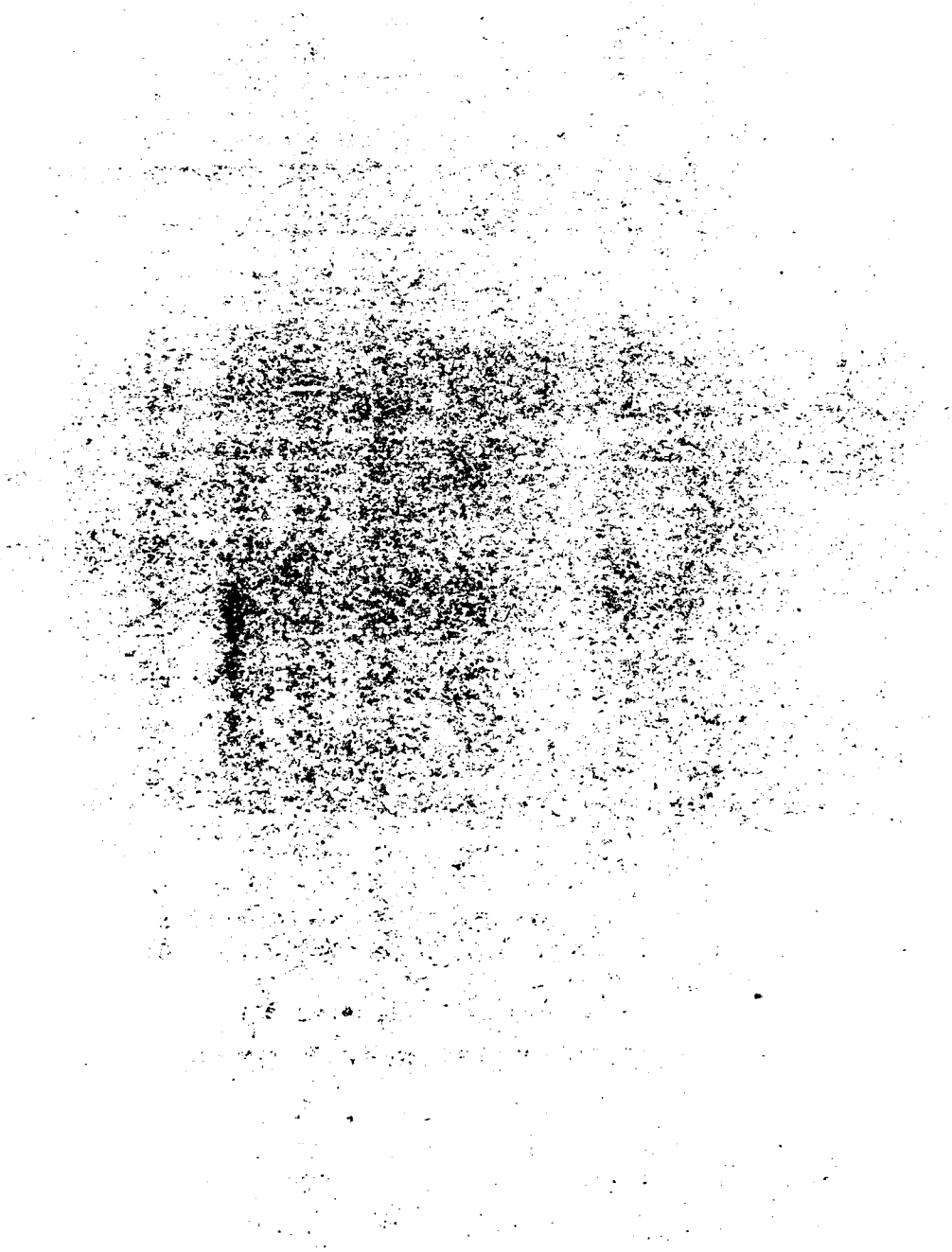
APPENDIX A



APPENDIX A

Military-Civilian Health Services Partnership Program

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF:

HSCL-M (310-2d) 29 January 1988

MEMORANDUM FOR: Commanders, HSC MEDCEN/MEDDAC

SUBJECT: Implementation of Military-Civilian Health Services Partnership Program

1. U.S. Army Health Services Command (HSC) medical treatment facility (MTF) commanders are hereby authorized to enter into agreements with civilian providers and institutions under the provisions of DODI 6010.12, "Military-Civilian Health Services Partnership Program," 22 October 1987, (Enclosure 1) as modified by this memorandum.

2. The Military-Civilian Health Services Partnership Program (hereafter called the Partnership Program) expands and replaces the Joint Health Benefits Delivery Program (JHBDP). This new program incorporates several desirable features not available under the old JHBDP. The Partnership Program:

a. Eliminates the requirement for the beneficiary to pay the CHAMPUS deductible and copayment if the care is provided in a military MTF (Internal Partnership Agreement).

b. Provides authority for military providers to treat CHAMPUS eligible patients in civilian medical facilities (External Partnership Agreement) thus saving both the government and the patient their apportioned cost of civilian provider fees.

c. Provides a simplified 30-day approval process for negotiated Partnership Agreements.

d. Allows for the payment of the costs of certain support personnel, equipment, and supplies furnished by the civilian provider when these resources are not otherwise available in the military MTF, provided the costs are included in the provider's allowable charges and the services are a CHAMPUS benefit. See definitions 5 and 6 on page 2-1 of DODI 6010.12 for an explanation of "other resources and support personnel."

e. Permits the MTF commander, as a provision of the Partnership Agreement, to use currently available supplemental care funds to provide for the treatment of noneligible CHAMPUS beneficiaries (i.e., active duty personnel, MEDICARE eligible dependents or retirees, dependent parents, etc.) at negotiated rates.

3. MTF commanders are encouraged to negotiate Partnership Agreements with local providers and institutions as a means of minimizing the total government cost of providing health services authorized on current mission templates.

a. Negotiators should obtain the lowest Partnership provider reimbursement rates consistent with high quality care and the requirements of the MTF.

b. CHAMPUS Fiscal Intermediaries (FI) are a source of data on prevailing charges within the catchment area. Analysis of the costs shall give due consideration to the reduced beneficiary payments under Internal Partnership Agreements.

c. Agreements should require maximum use of MTF support personnel, services, equipment, and supplies.

4. Processing agreements:

a. Approval authority for Partnership Agreements has been delegated to Headquarters, U.S. Army Health Services Command (HQ HSC) and the CHAMPUS FI serving the area where the MTF is located. Each FI has designated a Partnership Program Coordinator to work with the MTF Partnership Program coordinator in resolving problems related to the program.

b. Internal Partnership Agreements will be signed and dated by the MTF commander and the Partnership provider. Groups or clinics are not acceptable unless each provider of the group or clinic signs a separate agreement. External Partnership Agreements will be signed by the MTF commander and an individual with designated authority to sign for the civilian institution. Mail the original to the CHAMPUS FI serving the MTF area and one copy to Headquarters, U.S. Army Health Services Command, ATTN: HSCL-M. Both will be sent by certified mail, return receipt requested (Authority: AR 340-32, 9 Mar 85, Paragraph 4-4b(5)(f)). Headquarters, HSC, and the CHAMPUS FI have 30 days from the time of receipt to review the agreements. If disapproval has not been received within 30 days of the later of the dates on which HSC and the FI receipted for the mailed copies, the agreement can be considered approved and treatment can be provided under its terms. However, to ensure CHAMPUS payment of claims, it is recommended that the CHAMPUS FI be contacted regarding the status of the agreement if FI approval has not been received within 30 days.

c. MTFs may modify the basic Internal Partnership Agreement outlined in DODI 6010.12 when there exists an MTF need for the same Partnership provider to treat not only CHAMPUS-eligible beneficiaries but also active duty personnel and other non-CHAMPUS eligibles on a planned nonemergency basis. Treatment of active duty personnel and other non-CHAMPUS eligibles will be paid from the MTF account for supplemental care.

d. MTF commanders will ensure that all new agreements meet the criteria outlined in paragraph 4a of DOD Instruction 6010-12. The copy forwarded to Headquarters, HSC, will include estimates of cost savings using the format prescribed in Enclosure 2. An overall net savings to the government must be demonstrated. Such savings will be in addition to the savings to the beneficiary resulting from the elimination of the patient cost share and deductible.

e. The MTF c mander will provide MTF clinic space, support personnel, equipm , and ancillary services to support a Partnership provide 's practice. The MTF can request that the Partnership provide supply, if needed, support personnel, equipment, and supplies. The cost of these, however, cannot be billed separately, and similar to normal private CHAMPUS practice, must be included in the negotiated Partnership provider rate. The final negotiated fee, regardless of any support personnel, equipment, and supplies, cannot exceed the current CHAMPUS area prevailing rate.

f. Partnership Agreements have been determined by the Office of the Assistant Secretary of Defense (Health Affairs) not to fall under the formal solicitation requirements of the Federal Acquisition Regulations. MTF commanders, however, must ensure that all appropriate licensed providers in the MTF area have an equal opportunity to participate in a Partnership Agreement. Objective selection criteria (e.g., provider rates, professional qualifications, availability, flexibility of hours, and special MTF requirements) shall be used by the MTF in selecting Partnership Agreement providers. More than one provider or group of providers may be selected as determined by the MTF in assessing its needs and the availability of MTF clinic space. MTFs must maintain a record of the factors used in making their selection. To conserve scarce CHAMPUS funds, every effort should be made by the MTFs to negotiate the most cost-effective Partnership Agreements with the providers determined to be the best qualified under the MTF objective selection criteria as applied equally to all interested potential providers.

g. Partnership Agreements shall expire in 2 years with an option to renew for an additional 2-year period. Continuation of a Partnership Agreement beyond the 2-year renewal period (i.e., beyond 4 years) shall require satisfying all the requirements of a new Partnership request. Requests for renewals shall be submitted to both HQ HSC and CHAMPUS at least 45 days prior to the expiration of the agreement. Renewals become effective the day after the anniversary date of the original agreement unless disapproval has been received from HQ HSC or OCHAMPUS. Requests for renewals received less than 30 days prior to the anniversary date of the original agreement cannot be processed in time for renewal on the anniversary date. Such agreements will then have to be resubmitted as new agreements.

h. Joint Health Benefits Delivery Program (JHBDP) Agreements were automatically converted to Partnership Agreements on 1 January 1988. They will be valid for the remainder of their former JHBDP period as long as they satisfy the claims processing procedures in paragraph 5, below and paragraph F.4 of DODI 6010.12. Every effort should be made to renegotiate JHBDP Agreements in light of the government's assuming the patient cost share.

5. Processing claims.

a. JHBDP claims for care provided after 1 January 1988 will be paid under the terms of the Partnership Program. No beneficiary cost share/deductible will be collected on care provided within the MTF. JHBDP providers should be advised not to collect a cost share from the beneficiary on these claims because the FI will pay the total rate negotiated in the JHBDP Agreement, provided it does not exceed the area prevailing rate and the claim is identified as a Partnership Agreement claim.

b. The MTF Medical Services Account Officer will collect the same inpatient charge under Internal Partnership Agreements that the patient would have paid if treated by a military provider.

c. Under External Partnership Agreements, civilian hospitals will continue to collect the applicable cost share from the beneficiary.

d. It is recommended that MTF commanders develop procedures to require that Partnership Program claims be submitted through the MTF. If this is not feasible because of the volume of claims, a system will be developed for randomly auditing the Partnership provider records and CHAMPUS Explanation of Benefits (EOB) statements to ensure that the Partnership provider has billed CHAMPUS correctly for the actual services rendered at the proper negotiated rates agreed to under this program.

e. All Internal Partnership Agreement claims (and JHBDP Agreement claims for care provided after 1 January 1988) must be stamped "PARTNERSHIP" in red ink on the front of each claim form. This is the FI's only way of identifying the claim for special processing and nondeduction of the beneficiary cost share. External Partnership Agreement claims should be stamped in red ink with the words "EXTERNAL PARTNERSHIP." The stamp should not obliterate any data recorded on the claim. Block 32 of the CHAMPUS Form 500 (yellow form) submitted for services provided under an Internal Partnership Agreement must also be marked "yes."

f. Beneficiaries are not liable for charges disallowed by CHAMPUS. MTF commanders are responsible for settling disputes concerning unpaid charges either by paying from supplemental care funds or by disallowing the charges as having been for services provided outside the terms of the agreement.

6. Partnership providers may not refer beneficiaries to themselves, the provider's group, or any organization where conflict of interest may result. The MTF commander may waive this requirement on a case-by-case basis when an acceptable alternative referral source is not available.

7. MTF commanders are responsible for ensuring that participating civilian providers meet the credentialing, licensure, and quality review standards outlined in AR 40-66, AR 40-1, and DODI 6010.12. The intent of paragraph 4c of DODI 6010.12 is to require that the civilian health care provider carry liability insurance that is usual and customary for his or her clinical specialty in the local civilian community. It should not be interpreted as requiring indemnification of the government when the government is found at fault.

HSCL-M
SUBJECT: Implementation of Military-Civilian Health Services Partnership Program

8. For purposes of medical summary reporting on the MED-302 report, internal workload under the Partnership Program shall be considered the same as that accomplished solely with MTF resources.

9. Use of the Partnership Program by a CHAMPUS-eligible beneficiary is voluntary. Beneficiaries shall not be denied a Statement of Nonavailability (NAS) if the required care is available solely through a Partnership Agreement. A sign will be posted in a conspicuous location in the patient waiting area servicing Partnership providers in the MTF. The sign shall read:

Military-Civilian Health Services Partnership Program

The following non-DOD affiliated, private health care practitioners are providing services at (Name of Facility) for your convenience through the Military-Civilian Health Services Partnership Program:

PRACTITIONERS	SERVICES

Use of the Partnership Program by a CHAMPUS beneficiary is voluntary. Questions or comments about the Partnership Program should be addressed to (local contact).

10. The point of contact for the Health Services Partnership Program at HQ HSC is Albert Schultz, CHAMPUS Division, Office of the Deputy Chief of Staff for Clinical Services, AUTOVON 471-6517/6791.

FOR THE COMMANDER:

2 Encl

THOMAS C. MUNLEY
Colonel, MS
Chief of Staff

Department of Defense
INSTRUCTION

October 22, 1987
NUMBER 6010.12

ASD(HA)

SUBJECT: Military-Civilian Health Services Partnership Program

References: (a) DoD Instruction 6010.12, "Joint Health Benefits Delivery Program," January 10, 1983 (hereby canceled)
(b) DoD Instruction 6010.8, "Administration of the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS)," October 24, 1984
(c) DoD Directive 6000.7, "Dissemination of Information on Medical Officers," July 29, 1982
(d) DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," March 1986, authorized by DoD Instruction 6010.8, October 24, 1984
(e) through (h), see enclosure 1

A. REISSUANCE AND PURPOSE

This Instruction:

1. Reissues reference (a).

2. Updates procedures to enable the Military Departments to make health care services in their medical treatment facilities (MTFs) more available to health care beneficiaries using the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and, to combine military and civilian health care resources to improve the cost-effectiveness of the DoD health care delivery system.

B. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense (OSD), the Military Departments, the Organization of the Joint Chiefs of Staff (OJCS), the Unified and Specified Commands, the Inspector General of the Department of Defense (IG, DoD), the Uniformed Services University of the Health Sciences (USUHS), the Defense Agencies, and DoD Field Activities (hereafter referred to collectively as "DoD Components"). The term "Military Services," as used herein, refers to the Army, Navy, Air Force and Marine Corps.

C. DEFINITIONS

The terms used in this Instruction are defined in enclosure 2.

Encl 1

D. POLICY

1. It is DoD policy to establish a Military-Civilian Health Services Partnership Program (hereafter called the Partnership Program) to integrate specific health care resources between facilities of the Uniformed Services and providers in the civilian health care community. It allows CHAMPUS beneficiaries to receive inpatient care and outpatient services through the CHAMPUS program from civilian personnel providing health care services in MTFs and from uniformed service professional providers in civilian facilities. This policy applies when the MTF is unable to provide sufficient health care services for CHAMPUS beneficiaries through the MTF's own resources.

2. Under this policy:

a. The DoD health care delivery system can operate more efficiently by using the CHAMPUS program to supplement the MTF rather than disengaging the patient to CHAMPUS, the more costly health care component.

b. Health care resources eligible for use under the Partnership Program include providers, support personnel, equipment, and supplies.

c. Charges that accrue to all CHAMPUS beneficiaries for care from a civilian health care provider in the MTF shall be the same as those for MTF patients under the care of a military health care provider (10 U.S.C. 1096(c)), reference (e).

E. RESPONSIBILITIES

1. The Secretaries of the Military Departments shall:

a. Encourage MTF Commanders and their staffs to implement the Partnership Program in their facilities.

b. Educate MTF Commanders and their staffs, beneficiaries, and interested civilian health care personnel about the Partnership Program with the assistance of OCHAMPUS as appropriate.

c. Monitor the savings accrued by using the Partnership Program.

d. Review and evaluate authority related to the Partnership Program operations in the Military Departments.

2. The Surgeons General of the Military Departments shall provide the authority to implement the Partnership Program based on prior approval of their Military Department Secretary.

3. The Director, Office of the Civilian Health and Medical Program of the Uniformed Services, subject to the direction of the Assistant Secretary of Defense (Health Affairs), shall:

a. Promulgate and manage benefit and financial policy issues related to the Partnership Program.

b. Develop a program evaluation process to ensure that the Partnership Program accomplishes the purpose for which it was developed.

c. Provide support for implementation of this Instruction consistent with DoD Instruction 6010.8, reference (b).

d. Provide such information as may be available, upon request, on the use and costs of health care services in a specific geographic area.

e. Develop and provide model partnership agreements to contain terms, conditions and procedures of the partnerships.

4. The Commanders of Military Medical Treatment Facilities, shall:

a. Analyze potential applications of the Partnership Program (including both internal and external partnership agreements) on a case-by-case basis and make a determination prior to entering into each partnership agreement that all of the following criteria are met in that case:

(1) Use of the Partnership Program will meet a need for health care services that is not adequately being met by, and cannot be met with, existing MTF resources.

(2) Use of the Partnership Program is more economical to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS program.

(3) Use of the Partnership Program is consistent with the mission of the MTF.

(4) Use of the Partnership Program is consistent with high standards of quality health care established for military treatment facilities.

b. In applying the criteria listed in paragraph E.4.a., above, take into account the following points of consideration:

(1) In verifying an unmet need for health care services, consider appointment waiting times, number of Nonavailability Statements issued for a particular service, CHAMPUS use in the area, and other pertinent factors.

(2) In reviewing cost impacts, make a comparison between CHAMPUS costs for that health care service in the community without use of the Partnership Program and providing the service through the Partnership Program. This comparison should take into account the extent, if at all, that the provider in an internal agreement will be supported by his or her own personnel and other resources under his or her direct control and supervision, and in external agreements, the provider fees which would otherwise be applicable under the regular CHAMPUS program.

(3) Ensure that the agreement does not compromise the mission of the facility, and that the health care resources to be provided are consistent with the level and type of health care resources generally provided by the MTF.

(4) Review the capability of the facility's credentialing process and quality assurance program to determine whether they are sufficient to monitor the partnership agreement, and consider both the nature and the number of such agreements for the facility.

c. Ensure that all liability issues relating to the Partnership Program are properly addressed and ensure that the participating civilian health care providers have sufficient liability insurance coverage to protect OCHAMPUS beneficiaries as well as the government.

d. Provide quality assurance controls through the medical staff appointment and reappointment procedures, the specific delineation of clinical privileges, periodic in-depth health care provider review and appraisal, and the stipulation that participating civilian health care providers adhere to MTF instructions and medical staff bylaws to the same extent required of Military Department health care providers. The usual Service procedures will be used to ensure notification of the Federation of State Medical Boards, the National Data Bank, and OCHAMPUS of those practitioners who have had their clinical privileges limited, suspended, or revoked while a participant in the Partnership Program (DoD Directive 6000.7, reference (c)).

e. Ensure that health care services provided CHAMPUS beneficiaries under the terms of the Partnership Program are consistent with the CHAMPUS range of benefits outlined in current DoD Directives and OCHAMPUS operating policies (DoD Directive 6010.8 and DoD 6010.8-R, references (b) and (d)). Services other than authorized CHAMPUS benefits may be provided in the MTF upon approval of the MTF Commander, in which case the MTF will be responsible for paying the health care provider's charges.

f. Ensure that providers who are potential participators in the Partnership Program are given fair selection opportunities to participate in the program through appropriate notification of opportunities, such as notice to local medical and professional societies, and objective selection standards.

g. Require participating health care personnel to the extent practical to use MTF health care resources, that is, specialty consultants, ancillary services, equipment, and supplies, when such resources are available.

h. Assist in providing appropriate administrative support as necessary to expedite participating health care personnel reimbursements, but not in violation of the prohibition against a Government employee acting as a representative for a claimant against the Government as provided for in 18 U.S.C. 203, 205, reference (h).

i. Encourage beneficiaries to use the services available under partnership agreements rather than those available through the regular CHAMPUS program for care that, in the absence of the Partnership Program, would require issuance of a Nonavailability Statement.

j. Compute charges for beneficiaries under the internal partnership agreement (not under external partnership agreements) as charges are computed for MTF care services (10 U.S.C. 1096(c), reference (e)).

k. Ensure that the participating civilian providers:

(1) Meet the licensing and privileging requirements of the MTF with an internal agreement (DoD Directives 6025.4 and 6025.6, references (f) and (g)).

(2) Agree to comply with all rules and procedures of the MTF.

(3) Provide full professional liability insurance covering acts or omission of such health care provider, as well as those of support personnel, not covered by 10 U.S.C. 1089, and other resources supporting that provider to the same extent as is usual and customary in civilian practice in the community.

(4) Qualify as an authorized CHAMPUS provider under DoD 6010.8-R, reference (d).

F. PROCEDURES

1. Before a partnership agreement may be executed and implemented, the commander of the military medical facility involved shall submit the proposed agreement to the Director, OCHAMPUS, or designee, and the Surgeon General of the appropriate Military Department, or designee. The agreement shall be effective in accordance with its terms on the 30th calendar day, or on the day of approval if earlier than the 30th calendar day, after the Director, OCHAMPUS and the Surgeon General receive it. If the agreement is disapproved, a written statement of reasons for disapproval shall be sent to both the military facility involved and either the Surgeon General or OCHAMPUS, whichever is appropriate. Disapproval by either the Surgeon General or OCHAMPUS shall constitute disapproval.

2. A partnership agreement may contain a provision to provide for supplemental care money to be paid to health care providers for active duty care and for other non-CHAMPUS beneficiary cooperative care.

3. A partnership agreement shall not last longer than 2 years with an option to renew for a 2 year period based upon mutual agreement between the military treatment facility and the civilian provider and may be renewed on its expiration in the same manner as new partnership agreements are established.

4. Notification must be made to providers with existing agreements under the Joint Health Benefits Delivery Program (JHBDP) of the Partnership Program and the need to convert the agreement. The converted agreement will be valid upon the signature of the civilian provider and the military medical commander for the duration of the JHBDP agreement. Beginning January 1, 1988, all agreements made under the JHBDP not then converted to partnership agreements shall be deemed to be partnership agreements for the purposes of this Instruction.

G. INFORMATION REQUIREMENTS

The MTF Commander shall provide semi-annual reports to the major medical command for consolidation to the Surgeon General of the appropriate Military Department and to the Director, OCHAMPUS. The reports shall include information on the numbers of partnership agreements in place, new agreements and expired ones during that period, the medical service discipline or provider category associated with the agreement, and an explanation of charges billed under the program. These reports will be due the last working day of June and September of each year.

H. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately. Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

William Mayer, M.D.

William Mayer, M.D.
Assistant Secretary of Defense
(Health Affairs)

Enclosures - 4
1. References
2. Definitions
3. Internal Partnership Agreement Model
4. External Partnership Agreement Model

REFERENCES, continued

(e) Title 10, United States Code, Sections 1089, 1096
(f) DoD Directive 6025.4, "Credentialing of Health Care Providers," February 11, 1985
(g) DoD Directive 6025.6, "Licensure of DoD Health Care Providers," July 18, 1985
(h) Title 18, United States Code, Sections 203, 205

DEFINITIONS

1. External Partnership Agreement. An agreement between an MTF Commander (of both hospitals and/or clinics) and a CHAMPUS authorized institutional provider whereby health care personnel employed by a military MTF provide medical services to CHAMPUS beneficiaries in a civilian facility, with authorized costs associated with the use of the facility financed through CHAMPUS in accordance with cost sharing policies outlined in DoD 6010.8-R, reference (d). See Enclosure 4.

2. Health Care Personnel. Full or part-time health care professionals and support personnel.

3. Health Care Providers. Civilian health care services personnel who participate in, and facilities which deliver, clinical patient care and services and who are authorized CHAMPUS providers.

4. Internal Partnership Agreement. An agreement executed between an MTF Commander (of both hospitals and/or clinics) and a CHAMPUS authorized civilian health care provider which will enable the use of civilian health care personnel or other resources to provide medical services to beneficiaries on the premises of the MTF. Charges for this care will be paid through CHAMPUS with beneficiary cost shares computed as for MTF services (10 U.S.C. 1096(c), reference (e)). See Enclosure 3.

5. Other Resources. Equipment, supplies, and any other items or facilities necessary for health care services, but not including health care personnel, when such other resources are used by or are needed to support a health care provider under a partnership agreement.

6. Support Personnel. Non-DoD personnel, not covered by 10 U.S.C. 1089, directly supporting a health care provider under a partnership agreement on the premises of the MTF, under the direct control and supervision of such provider, during the delivery of health care, in the same manner as would be usual and customary in a normal health care office or other applicable clinical setting in the civilian community.

MEMORANDUM OF UNDERSTANDING

BETWEEN THE (enter name of MTF) AND (enter name of provider)

CITY OF _____ STATE _____

A. GENERAL

1. This agreement is entered into by and between _____, hereinafter referred to as the hospital, and _____, hereinafter referred to as the participating health care provider.

2. The purpose of this agreement is to integrate specific _____ hospital and CHAMPUS program resources to provide _____ services for CHAMPUS beneficiaries in (enter name of MTF).

3. The participating health care provider is licensed to practice medicine in the State of _____ and has completed application for clinical privileges at the hospital for the purpose of practicing medicine in (enter specialty). The participating health care provider agrees to all the terms and conditions of the application for clinical privileges at the hospital as well as the terms and conditions of this Memorandum of Understanding.

4. The hospital is a U.S. Government health care facility within the Department of Defense operated by the U.S. Department of the _____. The hospital is accountable to the Surgeon General of the Department of the _____ as the equivalent of the Board of Trustees. The commander of the hospital is the local representative of the Board of Trustees and is responsible for the operation of the hospital.

B. ARTICLES OF AGREEMENT

1. The hospital commander, or designee, shall:

a. Review past and current performance of, determine qualifications of (including review of liability insurance coverage), and select potential participating health care providers.

b. Comply with Utilization Review and Quality Assurance Directives and regulations of the Department of the _____, including but not limited to:

(1) Ensuring that participating health care providers are credentialed in accordance with DoD and Military Department regulations and the hospital bylaws.

(2) Ensuring that participating health care providers adhere to the Department of the _____ hospital bylaws and DoD and Military Department regulations to the same extent and in the same manner as Department of the _____ health care providers.

c. Provide facilities, ancillary support, diagnostic and therapeutic services, and equipment and supplies necessary for the proper care and management of patients under this agreement to the extent available and authorized for that facility.

d. Provide administrative support to participating health care providers to the extent available and authorized for that facility, including:

(1) Maintenance of patient records, including transcription and copying service as may be necessary to satisfy both (enter Military Department) and private practitioner recordkeeping requirements.

(2) Maintenance of participating health care provider case, workload, and credentials files in support of credentialing processes.

(3) CHAMPUS administration requirements, including certification and submission but only to the extent that it is not prohibited by 18 U.S.C. 203, 205.

(4) Reasonable accommodations within the hospital for such periods of time as the participating health care provider may be on after-hours call.

(5) Authorizing subsistence at hospital dining facilities at the rates prescribed for civilian guests.

e. Educate (enter Military Department) hospital staff personnel, beneficiaries, participating health care providers, and other interested civilian providers about the Partnership Program.

f. Provide appropriate reimbursement for care rendered in the hospital to patients not eligible for CHAMPUS benefits.

g. Encourage beneficiaries to use the services of this agreement rather than other CHAMPUS services for care that, in the absence of the Partnership Program, would require issuance of a Nonavailability Statement.

2. The Participating Health Care Provider shall:

a. Meet the licensing and privileging requirements of the MTF (DoD Directives 6025.4 and 6025.2).

b. Monitor overall inpatient medical care and outpatient services that are directly related to the inpatient medical care of patients referred as a part of this agreement except that portion of care rendered by or at the direction of (enter Military Department) health care providers.

c. Provide full professional liability insurance covering acts or omission of such health care provider, as well as those of support personnel not covered by 10 U.S.C. 1089 and other resources supporting that provider as part of this agreement to the same extent as is usual and customary in civilian practice in the community.

d. Provide personal liability coverage applicable to clinical privileges granted with indemnification of the U. S. Government as a third-party beneficiary.

e. Provide full disclosure of all information, including but not limited to past performance as required by the credentialing process.

f. Abide by hospital bylaws and DoD and Military Department regulations with regard to Utilization Review and Quality Assurance Directives, including but not limited to inservice training, maintenance of records, utilization review, performance evaluation, release of medical information, and credentialing.

g. Abide by unique (enter Military Department) requirements concerning the nature of limited privileged communication between patient and health care provider as may be necessary for security and personnel reliability programs.

h. Use all available (enter Military Department) resources; that is, specialty consultations, ancillary services, and equipment and supplies for the optimal care of patients under this agreement.

i. Adhere to the CHAMPUS Health Care Provider Agreement and claim submission requirements concerning allowable payment for services rendered.

C. OTHER CONSIDERATIONS

1. Neither party shall assign, transfer, convey, sublet, or otherwise dispose of this agreement or the right, title, or interest therein, or the power to execute such agreement, to any other person, company, or corporations, without the other party's previous written consent.

2. In the event of illness or incapacity rendering the participating health care provider incapable of delivering services, care for patients under this agreement shall be transferred to other participating health care providers at the discretion of the commander of (enter Military Department hospital).

3. The minimum term of this agreement is 2 years with the option to renew for a 2-year period based upon mutual agreement. Termination of this agreement shall be predicted upon satisfactory written notice to the other party not less than 90 days before the proposed termination date. However, the 90-day notice may be waived by mutual consent of the parties to the agreement or unilaterally for the convenience of government, including its mobilization requirements.

4. It is understood that the participating health care provider shall abide by (enter Military Department) rules concerning the confidentiality of patient records, as embodied in the Privacy Act of 1974.

5. Participating health care providers shall abide by (enter Military Department) regulations concerning release of information to the public, including advance approval from the (enter Military Department) before publication of technical papers in professional and scientific journals.

6. It is understood that no care rendered pursuant to this agreement will be a part of a study, research grant, or other test without the written consent of the hospital, OCHAMPUS, and the Assistant Secretary of Defense (Health Affairs).

7. The hospital's liability for actions of its employees (hospital staff and Military Department practitioners, but excluding participating health care providers) is governed by Title 10, United States Code, Section 1089.

IN WITNESS WHEREOF, each of the parties hereunto has executed this agreement effective on this _____ day of _____. 19____.

UNITED STATES OF AMERICA

By _____

Title _____

PARTICIPATING HEALTH CARE PROVIDER

_____
Name

_____
Address

MEMORANDUM OF UNDERSTANDING

BETWEEN THE (enter name of MTF) AND (enter name of civilian facility)

CITY OF _____ STATE _____

A. GENERAL

1. This agreement is entered into by and between _____, hereinafter referred to as the military treatment facility, and _____, hereinafter referred to as the civilian facility.

2. The purpose of this agreement is to integrate specific military treatment facility, CHAMPUS program and civilian facility resources to provide _____ services for CHAMPUS beneficiaries in the civilian facility. Military treatment facility resources includes, but is not limited to, Uniformed Service professional providers.

3. The military treatment facility will assure that its Uniformed Service professional provider whom it puts forth to provide the services of this agreement is licensed to practice medicine in a U. S. jurisdiction and will qualify for clinical privileges at the civilian facility for the purpose of practicing medicine in (enter specialty). The Uniformed Service professional provider remains under the authority of the military medical treatment facility to which he or she is assigned.

4. The civilian facility is separate from the U. S. Government and is responsible for its own operation.

B. ARTICLES OF AGREEMENT

1. The military treatment facility commander, or designee, shall:

a. Select potential participating civilian health care facilities based on review of past and current performance and a determination of its quality to provide care.

b. Maintain Utilization Review and Quality Assurance oversight of the participating Uniformed Service professional provider during his or her service in the participating civilian facility.

c. Educate (enter MTF) staff personnel, beneficiaries, participating civilian facility, and other interested civilian providers and facilities about the Partnership Program.

d. Provide beneficiaries who are eligible for care under this agreement with appropriate assistance in determining the specific CHAMPUS benefit to which they have access under this agreement.

2. The military treatment facility commander shall assure that the Participating Uniformed Service Professional Provider whom he assigns to fulfill the terms of this agreement shall:

a. Monitor overall inpatient medical care and outpatient services that are directly related to the medical care of patients referred as a part of this agreement.

b. Abide by civilian facility bylaws to the extent they do not conflict with DoD and Military Department regulations with regard to Utilization Review and Quality Assurance Directives, including but not limited to inservice training, maintenance of records, utilization review, performance evaluation, release of medical information, and credentialing.

c. Use (enter Military Department) resources to the extent practical for the optimal care of patients under this agreement.

3. The Participating Civilian Facility shall:

a. Provide facilities, ancillary support, diagnostic and therapeutic services, and equipment and supplies necessary for the proper care and management of patients under this agreement.

b. Provide administrative support to participating Uniformed Service professional providers as necessary, including:

(1) Maintenance of patient records, including transcription and copying service as may be necessary to satisfy both (enter Military Department) and civilian facility recordkeeping requirements.

(2) Reasonable accommodations within the civilian facility for such periods of time as the participating Uniformed Service professional provider may be providing care in the facility.

c. Be responsible for personal liability coverage applicable to all civilian facility personnel who may assist the participating Uniformed Service professional provider and hold the Government harmless for any fault that may result from such support personnel act or omission.

d. Adhere to CHAMPUS claims submission requirements for both the institutional charges and those professional charges for which it bills.

C. OTHER CONSIDERATIONS

1. Neither party shall assign, transfer, convey, sublet, or otherwise dispose of this agreement or the right, title, or interest therein, or the power to execute such agreement, to any other person, company, or corporations, without the other party's previous written consent.

2. In the event of illness or incapacity rendering the participating Uniformed Service professional provider incapable of delivering services, care for patients under this agreement may be transferred to other Uniformed Service professional providers at the discretion of the military treatment facility.

3. The minimum term of this agreement is 2 years with the option to renew for a 2-year period based upon mutual agreement. Termination of this agreement shall be predicted upon satisfactory written notice to the other party not less than 90 days before the proposed termination date. However, the 90-day notice may be waived by mutual consent of the parties to the agreement or unilaterally for the convenience of the Government, including its mobilization requirements.

4. It is understood that the participating civilian facility shall abide by (enter Military Department) rules concerning the confidentiality of patient records, as embodied in the Privacy Act of 1974.

5. Participating civilian facilities and its personnel shall abide by (enter Military Department) regulations concerning release of information on matters pertaining to, or services delivered under, this agreement to the public, including advance approval from the (enter Military Department) before publication of technical papers in professional and scientific journals.

6. It is understood that no care rendered pursuant to this agreement will be a part of a study, research grant, or other test without the written consent of (enter name of the military treatment facility), OCHAMPUS, and the Assistant Secretary of Defense (Health Affairs).

IN WITNESS WHEREOF, each of the parties hereunto has executed this agreement effective on this _____ day of _____. 19____.

UNITED STATES OF AMERICA

By_____

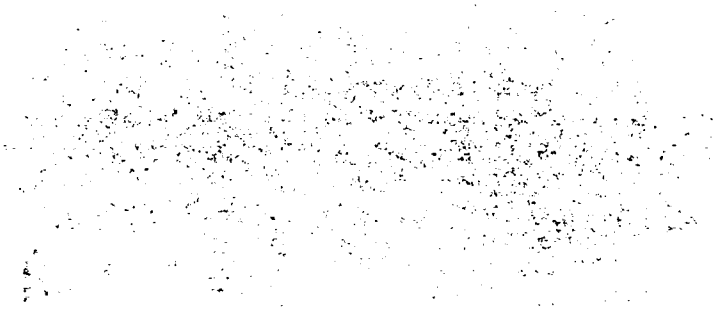
Title_____

AUTHORIZED SIGNER FOR
PARTICIPATING HEALTH CARE FACILITY

_____
Name

_____
Address

APPENDIX B



APPENDIX B

Extract of Current Procedural Terminology Codes for Maternity Care

59101 with tubal ligation

59105 Hysterotomy, abdominal, for legal abortion;

59106 with tubal ligation

EXCISION

59120 Surgical treatment of ectopic pregnancy; tubal, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach

59121 tubal, without salpingectomy and/or oophorectomy

59125 ovarian, requiring oophorectomy and/or salpingectomy

59126 ovarian, without oophorectomy and/or salpingectomy

59130 abdominal

59135 interstitial, uterine pregnancy requiring hysterectomy, total or subtotal

59140 cervical

59160 Dilation and curettage for postpartum hemorrhage (separate procedure)

INTRODUCTION

(For intrauterine fetal transfusion, see 36460)

(For introduction of hypertonic solution and/or prostaglandins to initiate labor, see 59850)

REPAIR

(For tracheloplasty, see 57700)

59300 Episiotomy or vaginal repair only, by other than attending physician; simple

59305 extensive

59350 Hysterorrhaphy of ruptured uterus; (separate procedure)

59351 following dilation and curettage, including both procedures

[redacted]

59400 Total obstetric care (all-inclusive, "global" care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care

59410 Vaginal delivery only (with or without episiotomy, forceps or breech delivery including in-hospital postpartum care (separate procedure)

59420 Antepartum care only (separate procedure)

59430 Postpartum care only (separate procedure)

CESAREAN SECTION

(For standby attendance for infant, see 99152)

59500 Cesarean section, low cervical, including in-hospital postpartum care; (separate procedure)

59501 including antepartum and postpartum care

59520 Cesarean section, classic, including in-hospital postpartum care; (separate procedure)

59521 including antepartum and postpartum care

59540 Cesarean section, extraperitoneal, including in-hospital postpartum care; (separate procedure)

59541 including antepartum and postpartum care

59560 Cesarean section with hysterectomy, subtotal, including in-hospital postpartum care; (separate procedure)

59561 including antepartum and postpartum care

59580 Cesarean section with hysterectomy, total, including in-hospital postpartum care; (separate procedure)

59581 including antepartum and postpartum care

ABORTION

59800 Treatment of abortion, first trimester; completed medically

59801 completed surgically (separate procedure)

59810 Treatment of abortion, second trimester; completed medically

59811 completed surgically (separate procedure)

59820 Treatment of missed abortion, any trimester, completed medically or surgically

59830 Treatment of septic abortion

59840 Legal (therapeutic) abortion, by dilation and curettage, and/or extraction

59841 Legal (therapeutic) abortion, by dilation and evacuation

59850 Legal (therapeutic) abortion, by one or more intra-amniotic injections (amniocentesis-injections) (including hospital admission and visits, delivery of fetus and secundines);

59851 with dilation and curettage

59852 with hysterotomy (failed saline)

OTHER PROCEDURES

59899 Unlisted procedure, maternity care and delivery

Endocrine System

(For pituitary and pineal surgery, see Nervous System)

THYROID GLAND

INCISION

60000* Incision and drainage of thyroglossal cyst, infected

APPENDIX C

APPENDIX C

CHAMPUS File Extract Report for Virginia

DEPARTMENT OF DEFENSE

OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

AURORA, COLORADO 80045-6900

BRL

21 FEB 1989

To: Health Benefits Advisor

Enclosed is a microfiche copy of the FY 88 CHAMPUS Pricing File Extract Report for your state. This report shows the CHAMPUS allowable charge for medical procedures in your state. One copy of the general description and a report explanation sheet for the FI servicing your region are enclosed.

Hope this information is helpful in your efforts to negotiate with providers.

Sincerely,

Edward Y. Walker III

Edward Y. Walker III
CAPT, USAF, MSC
Air Force Liaison Officer

Enclosures

DESCRIPTION AND USE OF CHAMPUS FISCAL INTERMEDIARY PRICING FILE EXTRACT REPORT

The CHAMPUS Fiscal Intermediary Pricing File Extract Report lists the most current prevailing fee levels as of the date of the report. These levels are as reported to OCHAMPUS by the Fiscal Intermediaries (FIs). In most cases, the pricing is that established by the FIs for the annual October update. Very little, if any, updating occurs during the year.

The prevailing levels are listed in procedure code order by FI for each state (and in state code order in the paper copy; see attached) within each FI's jurisdiction. The procedure codes used are from the Physicians' Current Procedural Terminology - Fourth Edition (CPT-4).

Only procedures for which prevailing levels have been established are listed. Procedures for which prevailing levels could not be developed due to insufficient billed charge data and procedures priced by methods other than by the prevailing charge method are not listed. Those not listed include procedures priced by conversion (including anesthesia procedures) and procedures priced "by report". See below for the OCHAMPUS telephone number to call for assistance with determining the CHAMPUS allowable amount for procedures not listed.

Some procedures may have more than one prevailing level listed for a given state. This occurs when different levels are established based on such distinctions as class of provider, e.g., physician vs non-physician, or type of service, e.g., professional component vs technical component for laboratory or radiology procedures.

In most instances, the codes used for these distinctions are unique to each FI. The attached explanations of the codes used under the headings "CPT-4 Modifier," "Specialty," and "Type of Service" should provide some assistance in understanding the distinctions when more than one prevailing level is listed.

For information on the methodologies used by CHAMPUS FIs to establish prevailing fee levels and determine allowable charges, please refer to the CHAMPUS Policy Manual (OCHAMPUS Manual 6010.47-M), Part Two, Chapter 3, and the CHAMPUS Operations Manual-Fiscal Intermediary (OCHAMPUS Manual 6010.24-M), Part Two, Chapter 4.

EXPLANATION OF CODES IN
CHAMPUS FISCAL INTERMEDIARY
PRICING FILE EXTRACT REPORT

FISCAL INTERMEDIARY: Wisconsin Physicians Service

SOUTH CENTRAL REGION: Arkansas (02), Kansas (15), Louisiana (17), Missouri (24), Oklahoma (34), Texas (40)

MID-ATLANTIC REGION: Delaware (07), District of Columbia (08), Maryland (19), North Carolina (31), Pennsylvania (36), South Carolina (38), Virgina (42)

CPT-4 MODIFIER This field is coded only to indicate when the prevailing fee listed on the line is other than 100% of the prevailing amount based on the following distinctions.

blank	100% of prevailing fee is listed. For radiology and laboratory/pathology procedures (7XXXX and 8XXXX, respectively) the prevailing fee listed is for the technical and professional components combined.
06	professional interpretation (medical procedures) - listed at 40% of the prevailing
10	technical component only for radiology or laboratory/pathology procedures - listed at 60% of prevailing
11	neuro-microsurgery - listed at 150% of the prevailing
15	multiple surgeries involving fingers or toes, third and subsequent procedures - listed at 25% of the prevailing
20	microsurgery - listed at 125% of the prevailing
26	professional component only for radiology and laboratory/pathology procedures - listed at 40% of the prevailing
50	procedure performed bilaterally - listed at 150% of the prevailing
51	multiple surgery for unrelated conditions, second and each subsequent procedures - listed at 50% of the prevailing

RUN DATE: 21 JAN 88
RUN TIME: 15:02:22

PRICING FILE EXTRACT REPORT
(PROCEDURE CODE WITH PREVAILING FEE > 0 AND FROM SEP 87 ONWARD)
FI: WISCONSIN PHYSICIANS SERVICE
STATE: VIRGINIA
CODE: 42

PROCEDURE CODE	CPT-4 MODIFIER	SPECIALITY CODE	TYPE OF SERVICE	PREVAILING FEE	FI EFFECTIVE DATE
58983	51 0		2	475.00	87/10/01
58984			2	1,600.00	87/10/01
58984	11 0		2	2,400.00	87/10/01
58984	20 0		2	2,000.00	87/10/01
58984	50 0		2	2,400.00	87/10/01
58984	51 0		2	800.00	87/10/01
58985			2	1,500.00	87/10/01
58985	11 0		2	2,250.00	87/10/01
58985	20 0		2	1,875.00	87/10/01
58985	50 0		2	2,250.00	87/10/01
58985	51 0		2	750.00	87/10/01
58986			2	1,025.00	87/10/01
58986	11 0		2	1,537.50	87/10/01
58986	20 0		2	1,281.25	87/10/01
58986	50 0		2	1,537.50	87/10/01
58986	51 0		2	512.50	87/10/01
58987			2	1,200.00	87/10/01
58987	11 0		2	1,800.00	87/10/01
58987	20 0		2	1,500.00	87/10/01
58987	50 0		2	1,800.00	87/10/01
58987	51 0		2	600.00	87/10/01
59000			R	150.00	87/10/01
59000	51 0		R	75.00	87/10/01
59020			R	75.00	87/10/01
59020	51 0		R	37.50	87/10/01
59025			R	120.00	87/10/01
59025	06 0		R	48.00	87/10/01
59025	10 0		R	72.00	87/10/01
59025	51 0		R	60.00	87/10/01
59120			R	1,612.00	87/10/01
59120	51 0		R	806.00	87/10/01
59160			R	600.00	87/10/01
59160	51 0		R	300.00	87/10/01
59400			R	1,300.00	87/10/01 ↔
59400	51 0		R	650.00	87/10/01
59410			R	1,050.00	87/10/01
59410	51 0		R	525.00	87/10/01
59420			R	220.00	87/10/01
59420	51 0		R	110.00	87/10/01
59420	56 0		R	370.00	87/10/01
59421			R	35.00	87/10/01
59421		92	R	25.00	87/10/01
59421	51 0		R	17.50	87/10/01
59421	51 0	92	R	12.50	87/10/01
59421	56 0		R	45.00	87/10/01
59430			R	40.00	87/10/01
59430	51 0		R	20.00	87/10/01

CHAMPUS FISCAL INTERMEDIARY

PRICING FILE EXTRACT REPORT
(PROCEDURE CODE WITH PREVAILING FEE > 0 AND FROM SEP 87 ONWARD)
FI: WISCONSIN PHYSICIANS SERVICE
STATE: VIRGINIA
CODE: 42

PROCEDURE CODE	CPT-4 MODIFIER	SPECIALITY CODE	TYPE OF SERVICE	PREVAILING FEE	FI EFFECTIVE DATE
59430	55 0		R	40.00	87/10/01
59500			R	1,450.00	87/10/01
59500	51 0		R	725.00	87/10/01
59501			R	1,600.00	87/10/01
59501	51 0		R	800.00	87/10/01
59521			R	1,800.00	87/10/01
59521	51 0		R	900.00	87/10/01
59801			R	600.00	87/10/01
59801	51 0		R	300.00	87/10/01
59811			R	600.00	87/10/01
59811	51 0		R	300.00	87/10/01
59820			R	550.00	87/10/01
59820	51 0		R	275.00	87/10/01
60100			2	185.00	87/10/01
60100	11 0		2	277.50	87/10/01
60100	20 0		2	231.25	87/10/01
60100	50 0		2	277.50	87/10/01
60100	51 0		2	92.50	87/10/01
61310			2	4,300.00	87/10/01
61310	11 0		2	6,450.00	87/10/01
61310	20 0		2	5,375.00	87/10/01
61310	50 0		2	6,450.00	87/10/01
61310	51 0		2	2,150.00	87/10/01
61518			2	4,500.00	87/10/01
61518	11 0		2	6,750.00	87/10/01
61518	20 0		2	5,625.00	87/10/01
61518	50 0		2	6,750.00	87/10/01
61518	51 0		2	2,250.00	87/10/01
62220			2	2,500.00	87/10/01
62220	11 0		2	3,750.00	87/10/01
62220	20 0		2	3,125.00	87/10/01
62220	50 0		2	3,750.00	87/10/01
62220	51 0		2	1,250.00	87/10/01
62223			2	3,250.00	87/10/01
62223	11 0		2	4,875.00	87/10/01
62223	20 0		2	4,062.50	87/10/01
62223	50 0		2	4,875.00	87/10/01
62223	51 0		2	1,625.00	87/10/01
62230			2	2,200.00	87/10/01
62230	11 0		2	3,300.00	87/10/01
62230	20 0		2	2,750.00	87/10/01
62230	50 0		2	3,300.00	87/10/01
62230	51 0		2	1,100.00	87/10/01
62270			2	125.00	87/10/01
62270	11 0		2	187.50	87/10/01
62270	20 0		2	156.25	87/10/01
62270	50 0		2	187.50	87/10/01

APPENDIX D

APPENDIX D

Ward Renovation Detailed Cost Estimate

Installation: Fort Lee
Date: 2 February 1988
Item Description: Retrofitting of third floor Wing C
Location: Kenner Army Community Hospital
Agency: Directorate of Engineering
Method: Contract

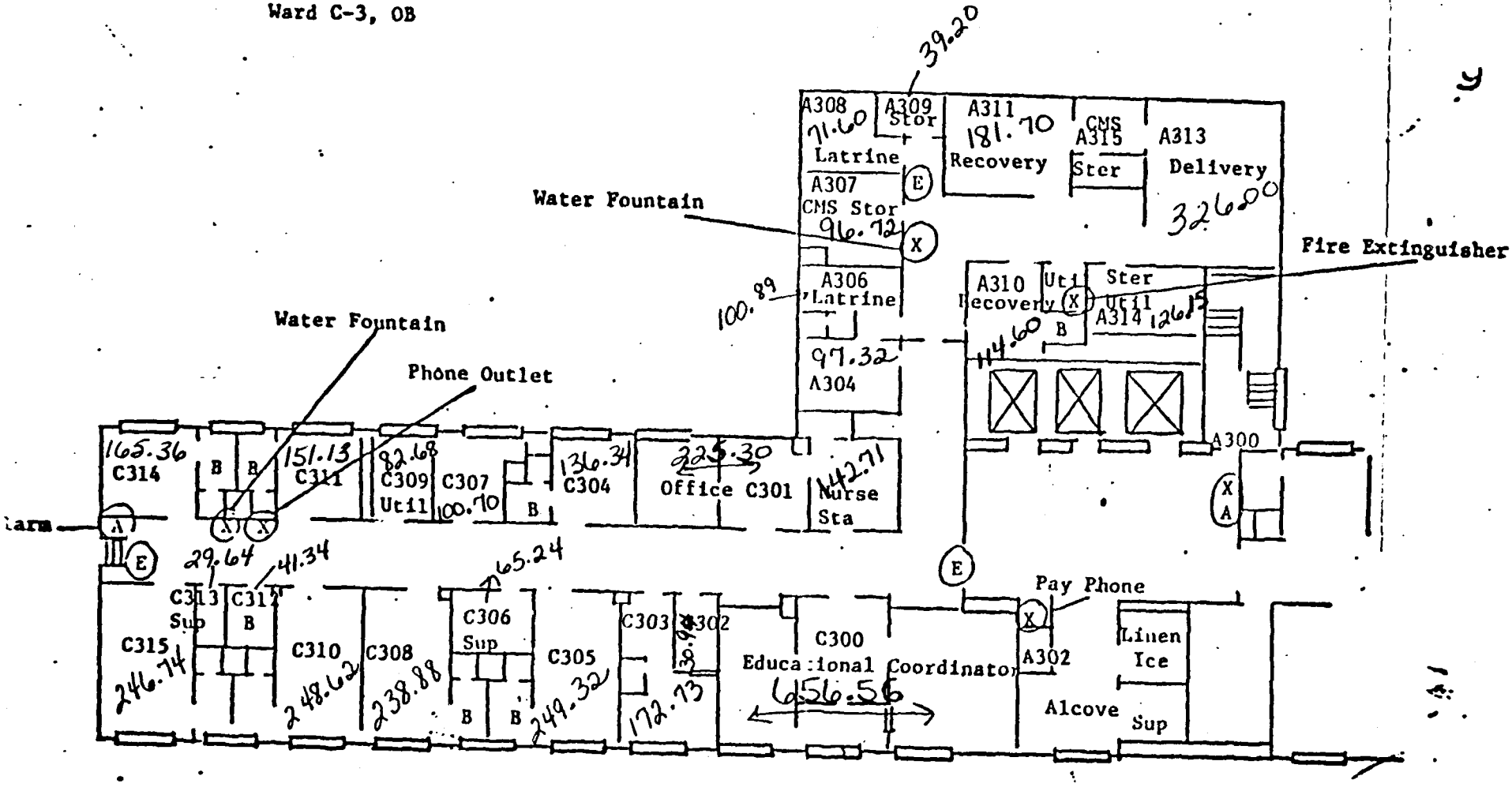
AREA	DESCRIPTION
Entrance Hallway	Automatic Doors
Room A-310 (Storage Room)	None
Room A-307 (Storage Room)	None
Room A-311 (OR Suite)	Repair Ceiling
	Patching/Painting
	Positive Pressure
	15 Air Changes/Hour
	Replace Door
	Emergency Power
	Install Electrical Receptacles
	Replace Broken Wall Tiles
	Install Humidity and Temperature Monitors
	Install Monometers for Checking Air Pressure
	Site Preparation for Installation of Two OR Lights
Hallway	Replace Ceiling Tiles
	Replace all scrub sinks
	Install Stainless Steel Shelving Above Sinks
Sub-Sterile Room	Site Preparation for Sterilizer and Solution Warming Cabinet
	Repair and Replace Wall Tiles
	Replace Ceiling Tiles
	Replace Two Doors-One to Each OR Suite
	Repair Lights
Room A-314 (Work Room)	Repair Ceilings
	Site Preparation for Sterilizer and Bedpan Washer
	Install Stainless Steel Shelving

Room A-309 (Supply Room)	Above Sinks
Room C-300 (Recovery Room)	Install Door
Way	Install Double Door Entrance to Area
	Install (4) Suction Outlets
	Install (1) Oxygen Outlet
	Install (4) Duplex Outlets
	Install Door
Miscellaneous	Paint the Entire Wing
	Replace Glass in Nursing Station
	Modify Bldg 8151A for Nursing
Education and Training's relocation	Renovate Nurse Call System
	Relocate Executive Housekeeping

Cost: $178,000

All of the electrical, air-pressure, safety deficiencies have already been identified and are scheduled to be corrected under the installation's electro-mechanical upgrade in Fiscal Year 1991. There is a continuing problem with inadequate amounts of air-exchange in the OR Suites resulting in an increased probability of post-operation and nosocomial infections.

THIRD FLOOR - WING A
THIRD FLOOR - WING C
Ward C-3, OB



Kenner Army Hospital, Building P-8130, Fort Lee, VA 23801

Total ward square footage: 5,553.22

APPENDIX E

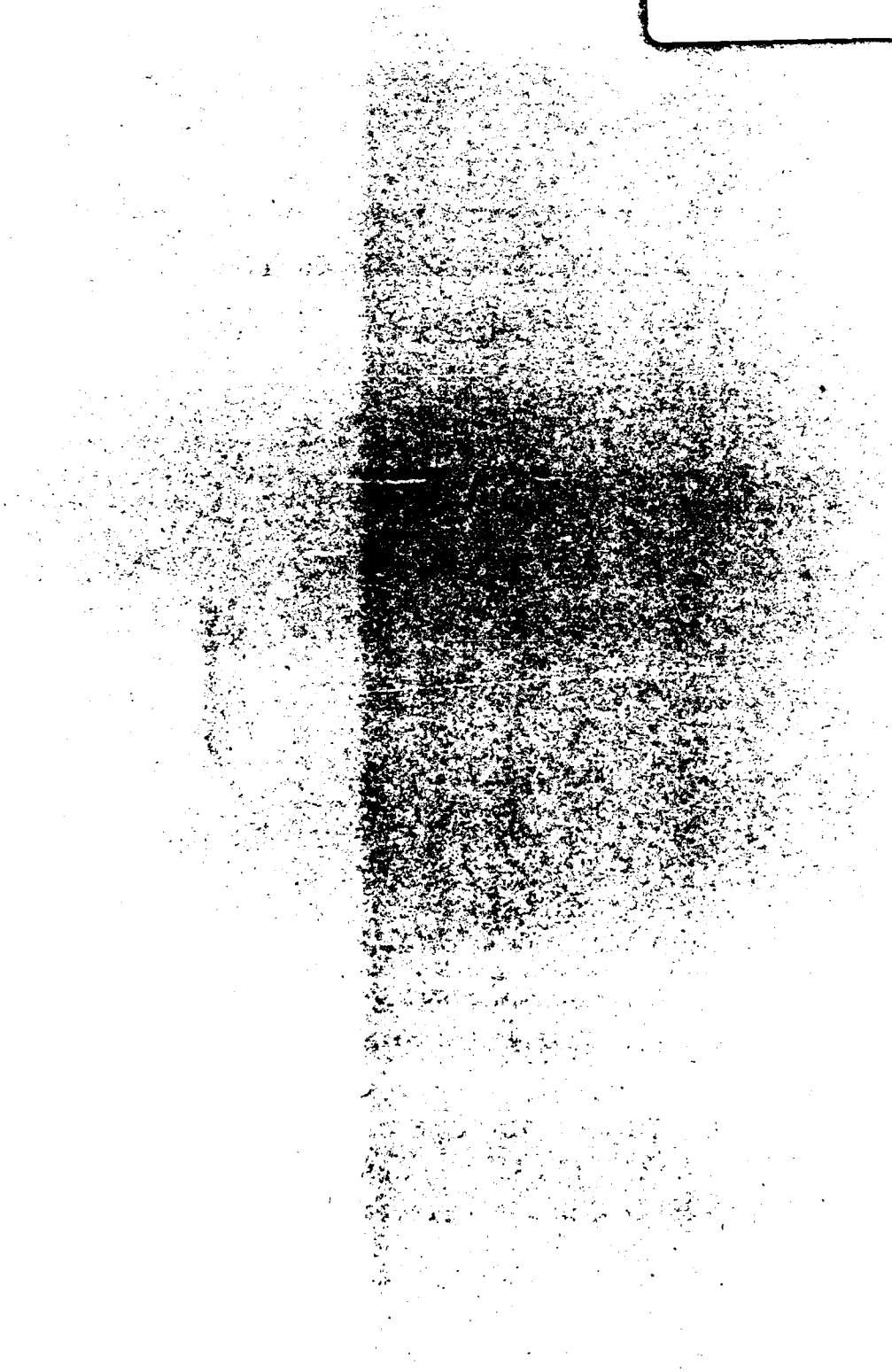
APPENDIX E

OB Staffing Cost Estimate

LABOR/DELIVERY/POST PARTUM	RANK/ GRADE	#	ANNUAL SALARY	TOTAL
Clinical Head Nurse	MAJ	1	$ 45,610	$45,610
Clinical Nurse	GS-09	6	$ 25,963	$155,778
Wardmaster	E7	1	$ 26,984	$26,984
Licensed Practical Nurse	GS-05	5	$ 17,134	$85,670
Nursery,				
Clinical Nurse 5	GS-09	5	$ 25,963	$129,81
Licensed Practical Nurse	GS-05	5	$ 17,134	$85,670
TOTAL		23		$529,527

*SOURCE: The Annual Direct Pay for the military and the total compensation for the civilian employees were obtained from the United States Army Finance and Accounting Center at Fort Benjamin Harrison, Indiana (1 January 1988).

APPENDIX F



APPENDIX F

EQUIPMENT LIST

STOCK NUMBER	QTY	NOMENCLATURE	UNIT PRICE
351000Q870003	2	CART LINEN/LOCK SMALL	642.69
351000Q870005	1	CART LINEN/LOCK LARGE	1100.82
351000Q870017	2	CART WIRE MEDICAL MAT W/4 SHELVES	422.53
351000Q870019	2	CART, ALL PURPOSE WIRE	819.50
411000Q876261	1	REFRIGERATOR ELECTRIC SMALL	265.74
411000Q876603	1	ICE MAKER	1812.61
582000Q875007	1	CONSOLE, VCR FOR 19 INCH MONITOR	541.51
583000Q876509AD	1	NURSE CALL-OBU	8193.12
623000Q876436	1	LAMP TABLE TEMPLE JAR	88.95
651500C035163	1	CURETTAGE UNIT VACUM BERKLEY MDL VC-11	1000.75
651501C720094	2	THERMOMETER FARENHEIT ELECTRONIC W/CHARGER	303.55
651501C725211	1	MONITOR FETAL PULSE	1305.42
651501C725442	2	PUMP INFUSION VOLUMETRIC	1834.71
651501C725596	1	MONITOR FETAL	10952.72
651501C725660	1	MONITOR OXYGEN	783.92
651501C725692	1	PUMP BREAST MECHANICAL	1106.39
651501C725694	1	STETHOSCOPE ULTRASOUND DOPPLER PULSE	833.96
651501C725707AA	1	MONITOR RESPIRATION SYSTEM INFANT	7927.61
651501C725707AB	1	WAVEFORM DISPLAY NON-FADE DUAL TRACE	
651501C725707AC	1	WAVEFORM RECORDER	
651501C725707AD	1	RESPIRATION RATE MONITOR	
651501C725753	1	HEATING UNIT FREE STANDING	3194.62
651501C725846	1	SCALE INFANT AND TODDLER	1496.12
651501C725969	1	MONITOR, PHYSIOLOGICAL SYST, EMSS	2258.21
651501C726026	1	FETAL HEART MONITOR	9937.20
651501C726162	1	OXIMETER, PULSE	1498.00
651501O763577	1	SUCTION APPARATUS OROPHARYNGENL PORTABLE	235.42
652000043120I	3	STOOL ADJUSTABLE RING FOOT REST	240.51
6520IC725038	1	ILLUMINATOR X-RAY FILM FOUR PANEL	333.58
652501C726094AA	1	SCANNER, ULTRASOUND, DIAGNOSTIC SYSTEM	13295.00
652501C726094AB	1	SCANNER, OB	
652501C726094AC	1	CAMERA, OSCILLOSCOPE	
652501C726094AD	1	TRANSDUCER, LINEAR, 3.5MHZ	
652501C726094AE	1	CART, FOR ULTRASOUND SCANNER SYSTEM	
653000C005004	1	BASSINET WARMING	2783.44
653000C005005	9	BASSINET WARMING, W/FULL CABINET, MATT	222.39
653000C005033	2	CART CRASH 3/DRAWERS	100.07
653000C005047	4	CHAIR ROCKING	111.19
653000C125188	3	LIGHT SURGICAL CEILING	3580.48
653000C195194	5	SURGI-GATOR RECESSED WALL MOUNTED	1534.48
6530007027000	3	CABINET SURG INSTR GLASS SIDES	783.95
6530007029000	2	CABINET MEDICINE COMB INSTR & DRESSING	670.29
6530007085255	1	STERILIZER STEAM WASHER BEDPAN & URINAL	667.17
6530009351089	3	INCUBATOR INFANT	3650.00

653001C720013	2	TRANSPORTER PATIENT	2001.51
653001C720017	1	NEONATAL CARE SYSTEM	5498.59
653001C720059	1	TRUCK MEDICAL RECORDS TAB, 42 PER TRUCK	257.97
653001C720063	1	CABINET PATIENT BEDSIDE	211.26
653001C720064	8	TABLE OVERBED W/VANITY	155.67
653001C720071	1	CART CHART MOBILE 20 CAPACITY	222.39
653001C720115	2	LIGHT SURGICAL EXAME FLOOR	750.57
653001C720121	1	TABLE EXAM	1044.45
653001C720123	1	CABINET MEDICINE BASE	378.06
653001C720124	1	CABINET TREATMENT	600.45
653001C720134	3	CABINET MOBILE 26X21X18	467.01
653001C722007	10	BED ADJUSTABLE ELECTRIC	1429.62
653001C725087	1	LIGHT BILIRUBIN	1758.26
653001C725105	1	TABLE OB/GYN DELIVERY	3508.47
653001C725414	1	MED SVC CNTR W/NARC LOCKER SINK REFRIG	1656.80
653001C725429	1	INCUBATOR INFANT TRANSPORT .	1656.80
653001C725438	10	HEADWALL SYS W/LOCKER BEDSIDE CABINET	5525.44
653001C725511	1	INCUBATOR INFANT TRANSPORT	1945.91
653001C725656	1	NEONATAL CARE SYSTEM	5496.36
653001C725744	1	BED BIRTHING	7116.48
653001C726078	5	MATTRESS PATIENT PROOF COIL SPRING	103.60
653001C725874	1	BILIMETER W/SENSOR	1008.05
667000C005003	1	SCALE INFANT CLINICAL 31 LB CAP	66.71
667001C720007	2	SCALE PATIENT WEIGHING	211.26
672000Q877101	1	CAMERA, INSTANT, W/FLASH ATTACHMENT	150.00
691001C726097	1	MODEL, BREAST, SELF-EXAM	65.00
710500Q876012	1	CHAIR CONVERTIBLE TO BED	416.98
710500Q876029	8	CHAIR W/O ARMS STACKING WOOD	110.07
710500Q876036	10	CHAIR PATIENT W/ARMS	144.55
710500Q876382	1	CHEST 3 DRAWER FOR OB BIRTHING ROOM	200.36
710500Q876383	1	CHEST/DESK 3 DRWR FOR OB BIRTHING ROOM	309.11
711000Q870089	4	GRAPHICS PACE EDITION ALL SIZES, SHAPES	100.07
711000Q876030	4	CHAIRS W/ARMS, CASTERS	211.26
711000Q876037	4	CHAIRS STRAIGHT W/ARMS, UPHOL	72.27
711000Q876039	1	TABLE ALL PURPOSE SQUARE OR RECTANGULAR	44.47
711000Q876040	1	TABLE ALL PURPOSE VARIOUS HEIGHTS	83.39
711000Q876043	4	CABINET FILING OR BOOKCASE 4 TIER	336.36
711000Q876045	1	DESK ATTACHMENT	452.00
711000Q876046	2	DESK W OR W/O BOOKSHELF TACKBOARD	583.76
711000Q876061	1	DESK PRIVATE W OR W/O SHELF ATTACHED	136.76
711000Q876218	1	CHAIR RECLINING UPHOLSTERED	166.79
7110001492065	2	CHAIR, SECRETARIAL	95.31
7110001774881	1	DESK WOOD DOUBLE PEDESTAL	270.00
7110011651875	1	WORK STATION 30 X 45 INCH	148.75
7125002698534	2	CABINET STORAGE	133.05
721000Q870001	1	BED DAY	100.07
721000Q876450	1	BEDSPREAD TWIN SIZE FLORAL PRINT	77.84
731000Q876536	1	MICROWAVE OVEN	271.21
732000Q876313	1	NOURISHMENT STATION	6433.66
743000Q876445	1	TYPEWRITER MEMORY-WRITER	2598.62
743000Q876605	1	MONITOR DISPLAY 9' FOR MEMORYWRITER	955.59

745000Q876173	1	CASSETTE VIDEO PLAYER	1173.11
745000Q876689AC	1	DICTATION STATION 4 CHANNEL PRIVATE WIRE	318.75
749000Q876115	1	EMBOSSING MACHINE	333.58
773000Q870002	5	TELEVISION COLOR 5 INCH W/REMOTE CONTROL	740.75
773000Q876008	1	TELEVISION COLOR 17 INCH	667.17
773000Q877247	1	TELEVISION, COLOR, 5 INCH, 12 CHANNEL	428.00

NUMBER OF ITEMS 201 TOTAL DOLLAR VALUE $ 253,819.81

APPENDIX G

APPENDIX G

Average Contract Cost in Fiscal Year 1988

APPENDIX H

APPENDIX H

CHAMPUS Assignment Agreement Form

AGREEMENT

NAME: John W. Bolen, M. D. ID# [redacted]

SPECIALITY: OB/GYN

ADDRESS: 106 Doctors Park

Galax, VA 24333

PHONE #: (703) 236-2909

(X) I agree to accept CHAMPUS assignment on a 100% basis. I understand that my name will appear on a list of providers willing to accept CHAMPUS and that the list will be made available to CHAMPUS beneficiaries.

( ) I would like to be visited by the CHAMPUS fiscal intermediary field representative.

( ) I am not willing to accept CHAMPUS assignment on a 100% basis.

DAte 12/3/86

Signature of Physician or Authorized Representative

COMMENT:

NOTE:

(1) A professional provider who accept CHAMPUS assignment agrees to the following:

a. To accept the amount CHAMPUS has determined to be a reasonable charge as full payment for services rendered.

b. To file claim with the CHAMPUS fiscal intermediary rather than to expect the patient to pay the full bill and file a claim for CHAMPUS.

(2) Professional providers signing the agreement retain the right to discontinue accepting CHAMPUS assignment on a 100% basis at any time. The provider is expected to inform the Health Benefits Advisor, Marise Bidgood, at 804-734-2941 when he or she makes the decision.

(3) A CHAMPUS fiscal intermediary field representative can assist you and your office staff with claims filing and advise you concerning allowable charges under CHAMPUS. The field representative for your area is Harvey Jenkins. He can be reached at: 804-487-7160.

DD-1-19
1 November 1986
EXP 30 July 1987

AGREEMENT

NAME: Carlos J. Blattner, M. D. ID# 54-1081530

SPECIALITY: OB/GYN

ADDRESS: 106 Doctors Park

Galax, VA 24333

PHONE #: (703) 236-2909

(X) I agree to accept CHAMPUS assignment on a 100% basis. I understand that my name will appear on a list of providers willing to accept CHAMPUS and that the list will be made available to CHAMPUS beneficiaries.

( ) I would like to be visited by the CHAMPUS fiscal intermediary field representative.

( ) I am not willing to accept CHAMPUS assignment on a 100% basis.

Date 12/3/86

C Blattner
Signature of Physician or Authorized Representative

COMMENT:

NOTE:

(1) A professional provider who accept CHAMPUS assignment agrees to the following:

a. To accept the amount CHAMPUS has determined to be a reasonable charge as full payment for services rendered.

b. To file claim with the CHAMPUS fiscal intermediary rather than to expect the patient to pay the full bill and file a claim for CHAMPUS.

(2) Professional providers signing the agreement retain the right to discontinue accepting CHAMPUS assignment on a 100% basis at any time. The provider is expected to inform the Health Benefits Advisor, Marise Bidgood, at 804-734-2941 when he or she makes the decision.

(3) A CHAMPUS fiscal intermediary field representative can assist you and your office staff with claims filing and advise you concerning allowable charges under CHAMPUS. The field representative for your area is Harvey Jenkins. He can be reached at: 804-487-7160.

OCD 1 19
1 December 1986
Exp 30 July 1987

APPENDIX I

APPENDIX I

Obstetricians/Gynecologists who have not agreed to accept Civilian Health and Medical Program of the Uniformed Services assignments in Virginia:

NAME:	ADDRESS:
M. Lassere	Clifton
H. Montgomery	Charlottesville
R. Fierro	Richmond
K. Shaughnessy	Richmond
R. Hall	Winchester
J. Meyer	Roanoke
B. Collins	Roanoke
R. Vermillion	J. Hancock
A. Jennings	Roanoke
J. Winn	Roanoke
J. Forth	Roanoke

Obstetricians/Gynecologists who have agreed to accept Civilian Health and Medical Program of the Uniformed Services assignment in Virginia.

NAME:	ADDRESS:
J. Bagley	Richmond
H. Bing	Stanton
J. Bolen	Galax
C. Blattner	Galax
S. Busch	Petersburg
J. Cummings	Petersburg
D. Branch	Roanoke
R. Cartanega	Norton
J. Cane	Richmond
J. Cross	Winchester
W. Cooksey	Richmond
A. Davis	Roanoke
W. Fitzhugh	Richmond
S. Farber	Roanoke
J. Garcia	Roanoke
D. Forrest	Richmond
C. Fleet	Richmond
P. Grossman	Richlands
M. Gospodnetic	Richmond
J. Goodner	Richmond
J. Ghramm	Winchester
J. Haddad	Richmond

J. Vinsel	Richmond
S. Solomon	Richmond
E. Harlfinger	Richmond
S. Hamilton	Richmond
S. Jarrell	Richmond
W. Icenhour	Blacksburg
V. Supetran	Hopewell
S. Worarat anadharm	Hopewell
C. Siri	Hopewell
D. McMillan	Stanton
J. Harrralson	Lexington
J. Jones	Richmond
B. Johnson	Richmond
E. Magann	Bluefield
J. Lowder	Winchester
C. Keblusek	Richmond
W. Jones	Richmond
D. Noonan	Charlottesville
C. Mcseley	Petersburg
T. Puray	Front Royal
J. Parker	Richmond
M. Reilly	Harrisonburg
K. Rao	Petersburg
E. Ruhnke	Petersburg
P. Rosanelli	Richmond
F. Shieh	Petersburg
R. Sedwick	Harrisonburg
L. Stockstill	Roanoke
J. Stafford	Winchester
S. Sultan	Pennington Gap
J. Turner	Farmville
F. Turner	Danville
W. Zirkle	Harrisonburg
I. Zibdeh	Norton

SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

Form Approved OMB No. 0704-0188

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12. PERSONAL AUTHOR(S): CPT PRADEEP G. GIDWANI

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
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16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

A study was conducted to determine the most cost-effective method of delivering obstetrical care to military beneficiaries within the Kenner Army Community Hospital's (KACH) catchment area. Six options were considered with the most plausible one being a joint venture between local hospitals providing obstetrical care and Kenner.

20. DISTRIBUTION/AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION
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22a. NAME OF RESPONSIBLE INDIVIDUAL	22b. TELEPHONE (Include Area Code)	22c. OFFICE SYMBOL
Lawrence M. Leahy, MAJ(P), MS	(512) 221-6345/2324	HSHA-IHC

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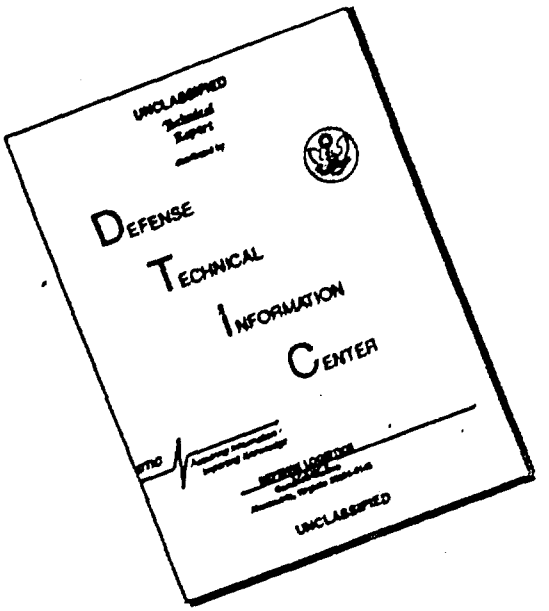

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